MEDICARE PROVISIONS IN THE PRESIDENT'S BUDGET

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

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MEDICARE PROVISIONS IN THE PRESIDENT'S BUDGET

THURSDAY, FEBRUARY 13, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:10 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
January 31, 1997
No. HL–1

CONTACT: (202) 225–3943

Thomas Announces Hearing on Medicare Provisions in the President's Budget

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on Medicare provisions in the President's budget. The hearing will take place on Thursday, February 13, 1997, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 9:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. Witnesses will include Dr. Bruce Vladeck, Administrator of the Health Care Financing Administration, budget experts, and actuaries. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Last year, the Medicare Trustees found that the Medicare Hospital Insurance (HI) trust fund would become insolvent by the year 2001. More recently, the Congressional Budget Office stated that for the Medicare HI trust fund to achieve full solvency beyond 10 years, Medicare's annual rate of growth must be slowed from 7.7 to 3.4 percent. Administration officials have publicly stated that the President's fiscal year 1998 budget would reduce Medicare spending by $100 billion from 1998 through 2002. Included in the proposal is a shift of a portion of home health expenditures from the HI trust fund to the Supplemental Medical Insurance trust fund, financed out of general revenues. This hearing will review the Medicare provisions included in the President's fiscal year 1998 budget, and begin to examine its impact on seniors, health care providers, health plans, and taxpayers.

In announcing the hearing, Chairman Thomas stated: "We are anxious to review the specific details of the President's proposal to achieve future solvency of the Medicare program. While the President's proposal appears to succeed in cutting costs, it may not make some of the structural changes to Medicare that would provide powerful market incentives to providers and health plans to improve quality and reduce costs, in addition to extending the solvency of the HI trust fund."

FOCUS OF THE HEARING:

This hearing will focus on the Medicare proposals included in the President's fiscal year 1998 budget and their impact on the Medicare Hospital Insurance trust fund.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement and

a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Thursday, February 27, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1904 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. The hour of 9 having arrived, the Subcommittee will come to order.

Today's hearing will focus on President Clinton's fiscal year 1998 budget proposal for Medicare. In light of the fact that the President and Congress could not come to an agreement on reforms to save Medicare in 1995 and the subsequent attention that was given to Medicare in the 1996 elections, it is now, in our opinion, largely up to the President to provide leadership on Medicare. And I believe that in this budget, he has recognized the challenges facing the program and has accepted his role in submitting a budget proposal which includes significant changes from his original proposal for Medicare.

The Chair takes the President's Medicare mandate seriously and views the President's budget proposal as at least "alive on arrival" for this Subcommittee to examine.

As the Members of the Subcommittee are keenly aware, in health policy, the devil truly is in the details, so it is the intention of the Chair, both today and during a series of hearings in February, March, and April, to dissect the President's proposal and assess its implications with great care.

From a preliminary review of the President's proposal, there is much for us to consider. The proposal is not as comprehensive as the 1995 congressional Medicare reform package and does not, in our opinion, save Medicare. However, it does include many of the ingredients of the 1995 Medicare bill which remain, obviously, worthy of adoption.

The President has chosen not as bold a route as we would propose in saving Medicare, but he has placed on the table a proposal that deserves the time and energy of this Subcommittee.

Our first witness today will be Bruce Vladeck, Administrator of the Health Care Financing Administration, at least for 1997; we know that he has announced his intention not to be around for 1998.

The Subcommittee welcomes Dr. Vladeck and looks forward to working with him as we consider the proposal that the administration has prepared. Before hearing from Dr. Vladeck, I would recognize the Ranking Member, the gentleman from California, Mr. Stark.

Mr. STARK. Well, thank you, Mr. Chairman.

I, too, think the President has a good plan. Insofar as we know now, it extends the life of the trust fund for 10 years, gives some peace of mind therefore to the seniors; it improves some benefits, increases fighting fraud, and modernizes the payments in a number of ways. Most of all, it avoids shifting more health care costs onto seniors, many of whom are desperately poor.

I would like to propose that this is a standard against which amendments could be measured. Anyone who wants to change it, increase rural or change something else, should be held to account as to whether they could keep the program solvent to 2007, whether they protect the poor in the safety net hospitals as the President's plan does.

I think yesterday Chairman Archer indicated that he felt our plan was not 100, it was 115 gross, and I think that that is about correct. That is $7.5 billion in extra benefits, which I am sure we all want to put in.

Mr. Chairman, I just propose that we take that range of 100 to 115—I will split it with you if you want—and let us mark it up. And why wait for the Budget Committee? We can figure it out. If that is what we have got to come up with, we have that laundry list up there; let us just roll up our sleeves and figure out how we are going to cut a little here and a little there and come up with 100—as I said, we are both saying it is 100 net or 115 if we want those extra benefits; if we do not want them, it is 100. So, let us go. Dr. Vladeck will tell us how to do it, and perhaps we can argue, and we will have some regional differences and provider differences, but I think we can get to work and get this done in short

order. I look forward to hearing the administration's suggestions, some of which I might want to change, some of which you might want to change, and we will get to work and deliver them a product.

Thank you very much.

Chairman THOMAS. I thank the gentleman.

I have said that the President's program appears to be long on reductions and somewhat murky on reform, and notwithstanding his enormous abilities, this Chair probably will not be willing to turn over to Dr. Vladeck the structure under which the changes would be made.

Dr. Vladeck.

STATEMENT OF HON. BRUCE C. VLADECK, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman, Mr. Stark, Members of the Subcommittee. I am very pleased to be here today to present the Administration's plan for modernizing Medicare and incorporating some of our initiatives to ensure that the program enters the next century in robust condition.

I am also very pleased in the context of some of my earlier experiences before this Subcommittee that we do in fact seem to have entered a somewhat different set of circumstances this year. All of the conversations, which I have had with Members from both sides of the aisle, have suggested to me a kind of willingness to talk about specifics and a willingness to work on issues. These conversations give us considerable optimism that we will, sooner rather than later, be able to work our way through the issues and to provide the kind of legislation that is needed for the program and needed for the American people. I very much look forward to that process and to negotiating with the Chairman on just how much discretion we will have over defining this structure.

Let me begin by saying that we always think it is important, particularly for those of us who spend most of our time inside the beltway, to start by putting a human face on some of these issues and to think about the context of the impact that our proposals would have on American citizens and on the beneficiaries, for whom the program exists and with whom we need to be primarily concerned.

If I could call your attention to the two charts which are to my right, copies of which should be with your copies of my testimony. Let me remind you that while only 10 to 12 percent of Medicare beneficiaries fall below the Federal poverty line, more than three-quarters have incomes of $25,000 a year or less. Medicare is often described as a middle-class benefit, but its beneficiaries are middle class precisely because they have Medicare benefits.

The second chart shows that with the availability of Medicare benefits, because of the limitations in the Medicare benefit package and because of their constrained incomes, the elderly already spend 2½ times as high a proportion of their total income on health expenses as do the nonelderly.

Our goal with this package is really threefold. We propose to extend the solvency of the Hospital Insurance Trust Fund for a decade; we hope to contribute in a very significant way to reduction

of the Federal deficit and to the President's plan to balance the budget by Federal fiscal year 2002. But most importantly, we need to lay the framework for a major modernization of the Medicare Program that will move us forward into the next century in some of the directions which we need to go.

First, let me very quickly highlight some of the more direct budgetary aspects of the proposal and then speak very briefly about some of the more structural reforms, for want of a better term.

In order to contribute to deficit reduction and to extend the life of the trust fund, we have a number of significant proposals. In the aggregate, these initiatives would reduce the per capita growth rate of Medicare outlays from the current projected baseline of approximately 7.4 percent per year to 5.3 percent per year. That number is very close, we believe, to the best available estimates of what the growth in the costs borne by other health insurers is likely to be over the same period of time.

About $33 billion in total savings over 5 years will come from reduction in payments to hospitals, including a reform of outpatient payment, which I will say more about in a moment, a reduction of the update factors to 1 percent per year below market basket, and some relatively modest changes in the way in which we reimburse hospitals for the direct and indirect costs of medical education. At the same time, some of these reductions are offset by our proposal to remove from payments to HMOs the costs attributable to medical education and to disproportionate share hospital payments and to pay these directly to the institutions.

We are proposing to save $14 billion over the budget period through the implementation of a case mix-adjusted prospective payment system for home health agencies and some other reforms in the way we pay home health agencies. Over the same period, we save about $7 billion through the implementation of prospective payment for skilled nursing facilities.

We have a series of interlocking changes in the way in which we pay managed care plans under the program. Most of the attention so far has focused on the proposal to reduce average payment levels in the year 2000 and thereafter from 95 percent to 90 percent of the AAPCC. At the same time, as I mentioned, we are going to pull out the teaching and disproportionate share components of the rates and pay these directly to the institutions.

We are also directly borrowing two concepts that were included in the 1995 legislation and that I have often said we think are the soundest pieces of that legislation—the proposal to reduce geographic disparities in payment rates by a slightly different method than that contained in the 1995 legislation, which produces essentially the same result of essentially averaging in a component of the national rates with the local rates on a phased-in basis. At the same time we are proposing, beginning in 1998, a floor of $350 a month in the capitation payment in any given county in the United States.

The interaction of all of these changes gets sort of complicated, and we also have some specific mechanisms to minimize the year-to-year impact of these changes in any given county which I would be happy to address further.

We are also proposing to save $7 billion over 5 years by slowing the rate of growth in payments to physicians and other providers, primarily by improving and modernizing the index by which we update physician fees from year to year in the context of moving to a single conversion factor for all physician payments.

We have a number of proposals aimed at reducing fraud and abuse in the program, including extension of certain secondary payer proposals and some proposals aimed at significant tightening of the administration and enforcement of the home health benefit.

Very quickly, let me walk through some of the components of our modernization proposals. We group these into seven areas, and the rubrics we use are: Prudent purchasing, modernizing managed care choices, preventive care, beneficiary protections, program improvements, integrated quality management, and improving access in rural areas. In my oral statement I will not go into any great detail about any of these, but let me very quickly mention that under prudent purchasing, we are seeking to adopt some of the more effective techniques for purchasing of health services that have been used in the private sector and applying these to the Medicare Program. We need to be able to contract with Centers of Excellence which can provide expensive services at very high volume with very high quality at some reduction in cost to us.

We need to have more flexibility in the way we pay for various common supplies so that we are not paying retail list or something above list, but something closer to an appropriate negotiated price.

We need to use the tools of competitive bidding in circumstances in which it is appropriate to create greater competition among suppliers to the Medicare Program.

We are also proposing, as you know, to restore the characterization of Medicare home health care benefits to something substantially closer to what was in the law prior to 1980. Under our proposal, the first 100 visits following a hospital stay of 3 days or more would continue to be a benefit under part A of the program. All other covered home health services would be paid under part B, as was the case before 1980.

We also have a set of proposals in the legislation that would permit us to modernize the administration of the Medicare Program, building on the work that was done by the Congress in a bipartisan way last year in HIPAA by giving us greater authority to pick and choose among the contractors who perform various administrative services for the program, to introduce greater competition in the world of contractors, and to let us employ more specialized services for issues like coordination of benefit or beneficiary services.

On the modernization of managed care, we propose in this legislation to open up Medicare contracting both to provider-sponsored organizations and preferred provider organizations. We do provide a mechanism for much expanded efforts at structured beneficiary choice by providing for third parties to provide beneficiaries with substantially better information about the plans available in their communities; toll-free consultation, consumer education services, and so forth.

We would emphasize that our plan extends information and open enrollment processes not only to capitated plans but to Medigap plans as well, and therefore our legislation also includes some pro-

posed reforms in the Federal law affecting Medigap policies similar in a number of important ways to the legislation that Mrs. Johnson, among other Members, introduced late last year to create a level playingfield between capitated and Medicare supplemental options.

We are also building on some work that is already underway on a bipartisan basis in this Congress to expand the preventive benefits in the Medicare Program. The legislation, which you, Mr. Chairman, Mr. Cardin, and Mr. Bilirakis have introduced, is not identical to our proposals for expanded preventive benefits, but I think we are thinking along somewhat the same lines, and we would be happy to talk about some of the differences in proposals and to work toward an agreement.

We are particularly pleased to be able to define a set of preventive benefits relative to the management of diabetes, which we think will have a particularly important effect not only on expenditures in the program over time, but on the health and well-being of our beneficiaries.

We are proposing, as I suggested earlier, to totally reform the way Medicare pays for hospital outpatient services. This will produce no net savings over the budget window, but what it will do is put an end to this growing trend in which beneficiaries, solely for hospital outpatient services, pay more than 20 percent coinsurance. We estimate that next year, in the absence of legislative change, the effect of coinsurance involving beneficiaries for hospital outpatient services would be 46 percent. Under our proposal, by the year 2007, we would be back to the 20 percent where that coinsurance belongs, while at the same time putting hospital outpatient services on a rational prospective payment system.

We are proposing a new respite benefit in the program beginning in 1998 that will provide caretakers of beneficiaries with Alzheimer's disease or other irreversible dementias up to 32 hours a year of direct care for the beneficiary to provide respite for care givers.

We are making major steps on the quality improvement front in both the capitated and fee-for-service side of the program. In order to pull together existing authorities and to clarify our responsibilities relative to data and quality improvement, we have some proposals in the bill under what we define as our integrated quality management strategy to bring the underlying statutory framework up to date in terms of contemporary notions of continuous quality improvement of information-based decisionmaking about quality and appropriateness of services.

Last, we continue to be very concerned about assuring access to Medicare beneficiaries in rural areas. In addition to the changes that we are making in the payment mechanisms for managed care plans, which we believe will have a very significant effect on rural communities, we are proposing to expand the rural primary care hospital program to all 50 States, something I know will be of great interest to Members of this Subcommittee. We also propose to strengthen and update other special payment provisions on the part A side which we have for a variety of rural institutions.

In conclusion, we have tried to look beyond the immediate concerns of budget reduction and to keep our sights on the long-term

goal of safeguarding the vitality of the Medicare Program. As our Nation evolves into a society with greater numbers of the elderly and infirm, it is critical that we preserve Medicare as a strong and vital program, and we believe the President's budget contributes to modernizing Medicare while extending the solvency of the trust fund for 10 years, reducing the rate of growth in spending, and contributing importantly to balancing the Federal budget, including eliminating the current Federal deficit.

Our payment reforms and strategies will ensure that Medicare continues to be a sound investment in the Nation's health security for years to come.

Mr. Chairman, we are mindful of the overlap between many of our proposals and proposals that you have supported in the past. We are mindful of other proposals which other Members of the Subcommittee have championed in the past, and we very much look forward to working with all the Members of the Subcommittee to achieve legislation this year that will strengthen and improve the Medicare Program for years to come.

Again, I am pleased to be here today, and I look forward to your questions and comments.

[The prepared statement and attachments follow:]

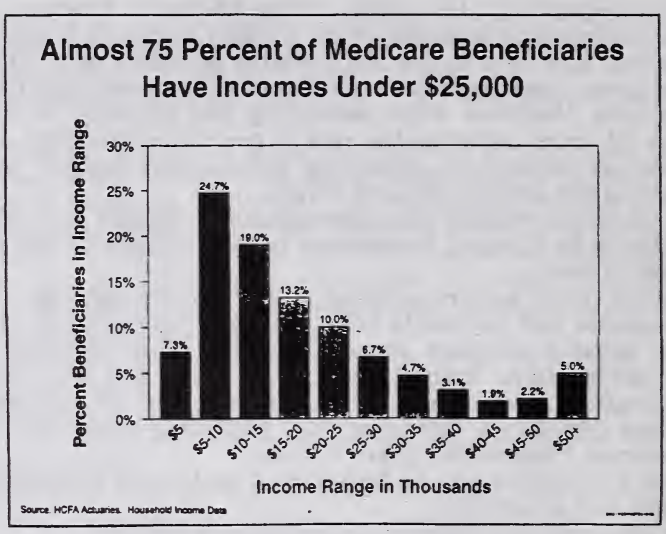
Statement of Hon. Bruce C. Vladeck, Ph.D., Administrator, Health Care Financing Administration

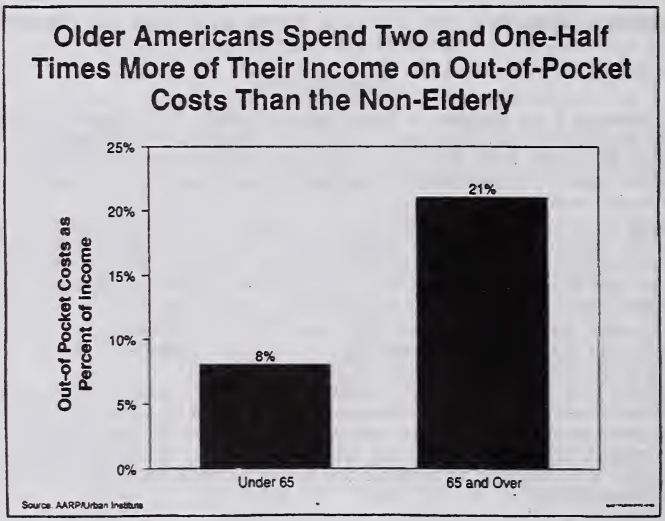
INTRODUCTION

Mr. Chairman, I am pleased to have the opportunity to present the Administrations plan for modernizing Medicare. I am enthusiastic about the initiatives we have undertaken to ensure that Medicare is strengthened for the 38 million Americans who depend upon it, offers the best possible medical care, and enters the next century in robust condition.

We think it is important to put a human face on the equation and to be fully aware of the serious impact such proposals would have on Americans least able to bear these additional cost burdens. Although only 10–12% of Medicare beneficiaries fall below the Federal poverty line, nearly 75% have incomes below $25,000. [CHART #1] Medicare is often described as a middle-class benefit, but beneficiaries are middle class precisely because they have Medicare. Recent data indicates that the elderly already spend a formidable 21% of their income on health care, compared to 8% spent by the non-elderly. [CHART #2]

The Medicare provisions in the President's FY 1998 Budget have two primary goals: (1) to extend the life of the Medicare Trust Fund into the next decade, which will contribute to reduction of the deficit; and (2) to modernize Medicare. Through sound judgment and careful planning, we can guarantee that the Medicare program of the future will continue to provide the same protections to the elderly and disabled as it does today.


Almost 75 Percent of Medicare Beneficiaries Have Incomes Under $25,000
Percent Beneficiaries In Income Range
30%
25%
20%
15%
10%
5%
0%
7.3%
24.7%
19.0%
13.2%
10.0%
6.7%
4.7%
3.1%
1.9%
2.2%
5.0%
$5
$5-10
$10-15
$15-20
$20-25
$25-30
$30-35
$35-40
$40-45
$45-50
$50+
Income Range in Thousands
Source: HCFA Actuaries. Household Income Data


Older Americans Spend Two and One-Half Times More of Their Income on Out-of-Pocket Costs Than the Non-Elderly
Out-of Pocket Costs as Percent of Income
25%
20%
15%
10%
5%
0%
8%
21%
Under 65
65 and Over
Source: AARP/Urban Institute

Extension of Medicare Solvency Into 2007

Under present law, the Hospital Insurance (HI) Trust Fund would be depleted early in 2001, based on the Board of Trustees' intermediate estimates. The President's budget proposals would extend the life of the Trust Fund by another 6 years. It would provide adequate financing through the next 10 years, leaving us time to tackle imminent fiscal problems precipitated by retiring baby boomers. Savings would be achieved through a combination of scored savings from reductions in payments to hospitals, home health agencies, skilled nursing facilities, managed care plans, and other providers. As was proposed in the previous two balanced budget initiatives, it would permanently extend the 25 percent Part B premium. Finally, the liability associated with some home health services would be reallocated to the Part B side of the program.

Moderating Medicare's Rate of Growth

The President's budget includes explicit proposals to achieve $100 billion in savings over the next 5 years. Medicare per capita spending growth over the next five years (1997–2002) will slow from the current projected gross rate of 7.4% to 5.3%. In 2002, this will lower our average per capita spending from $7,800 to $7,100. These savings come from substantial reductions in payments to providers.

Hospitals—We propose a series of hospital savings proposals, including a reduction in the hospital PPS update of 1.0 percentage point each year to account for increases in productivity, reinstatement of the reduction in capital payments from OBRA 90, reforms to the direct payment for medical education to reduce the growth of hospital-based residents and encourage more training in primary care, and reductions in the indirect medical payment to more closely reflect the cost of teaching activities. In addition, we propose to use a more up-to-date base year in calculating payments to PPS-exempt hospitals, to set ceilings and floors for these hospitals's target rates, and to reduce the annual update to payments and cut capital payments for PPS-exempt hospitals. We also propose a moratorium on new long-term care hospitals and to move to a PPS for hospital outpatient department services. Overall, these proposals result in $33 billion in savings from hospitals over 5 years.

SNF and Home Health—As I will describe in detail later, we will be moving to case-mix adjusted prospective payment systems for these providers. These payment systems will incorporate payment reductions equal to $7 billion for SNFs and $14 billion for home health agencies (HHAs) over five years.

Managed care—Through a series of policy changes, the plan would address the flaws in Medicare's current payment methodology for managed care. Specifically, the reforms would create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor, would dramatically reduce geographical variations in current payment rates. The plan would reduce reimbursement to managed care plans by approximately $34 billion over 5 years. Savings will come from three sources: (1) Because HMO payments are updated based on projections of national Medicare per capita growth, when the traditional fee-for-service side of the program is reduced, HMO payments are reduced; (2) The carve-out of the medical education and DSH payments from the HMO reimbursement formula (these funds will be paid directly to academic health centers); and (3) A phased-in reduction in HMO payment rates from the current 95% of fee-for-service payments to 90%. A number of recent studies have validated earlier evidence that Medicare significantly overcompensated HMOs. A recent HCFA study has validated earlier findings by Mathematica Policy Research that Medicare overpays HMOs. The reduction does not start until 2000 and it accounts for a relatively modest $6 billion in savings over 5 years.

Physicians—We propose to establish a single conversion factor for payments under the physician fee schedule and to reform the method for updating physician fees. By creating incentives to control physician services in high-volume inpatient settings and to make a single payment for surgery where an assistant-at-surgery is used, costs will be reduced. We also propose to expand the settings in which direct payment is made to physician assistants, nurse practitioners and clinical nurse specialists to include home and ambulatory settings. Medicare currently does not have an expansive outpatient drug benefit, though there is coverage of certain kinds of outpatient drugs. Our proposed plan will eliminate the mark-up charged by physicians and suppliers, limiting payments to acquisition costs subject to a limit. In addition to eliminating the current statutory x-ray requirement to determine the need for a service, we also propose to improve access to chiropractic services. These proposals will result in savings of $7 billion over 5 years.

Fraud and Abuse

The President's budget contains a number of proposals to reduce waste, fraud and abuse in the Medicare program. Among these proposals are provisions to require that insurance companies report the insurance status of beneficiaries, to guarantee that Medicare pays appropriately. In addition, we have several proposals to prevent excessive and inappropriate billing for home health services. We are proposing to close a loophole in the current payment calculation by linking payments to the location where care is actually provided, rather than the billing location. When we implement the PPS, we will eliminate HHA periodic interim payments (PIPs), which were originally established to encourage HHAs to join Medicare by providing a smooth cash flow. Since over 100 new agencies join Medicare each month, inducements are no longer needed. We will develop more objective criteria for determining the appropriate number of visits per specific condition, so that we can prevent excessive utilization.

Finally, the President's budget calls for the repeal of several provisions in the HIPAA that could hamper our ability to fight fraud and abuse. First, the President is proposing to eliminate the broad new exception to the anti-kickback statute when providers are at a substantial financial risk. These terms are undefined and somewhat broad. Additionally, the Congressional Budget Office assigned a cost to this provision because it could be easily abused by those wishing to profit from referrals. Second, the President is proposing to eliminate the requirement that advisory opinions be issued in response to specific requests as to how certain business arrangements may or may not be considered to violate the anti-kickback laws. This provision will hamper the government's ability to prosecute fraud and is impractical because it is difficult, if not impossible, to determine intent based on the submission of the requestor. Third, the President is proposing to reinstate the "reasonable diligence" standard. HIPAA eliminated the current standard for use of reasonable diligence and made providers subject to civil monetary penalties only if they act with deliberate ignorance or reckless disregard.

Modernizing Managed Care Choices

The President's Budget modernizes Medicare and brings it into the twenty-first century through major structural changes in seven areas: Prudent Purchasing; Modernizing Managed Care Choices; Preventive Care; Beneficiary Protections; Program Improvements; Integrated Quality Management; and Improving Access in Rural Areas.

1—Prudent Purchasing

As more beneficiaries are choosing to enroll in managed care, there has been a lot of talk about fee-for-service being the "residual" as though it were somehow not important. We must recognize that even if we double the rate at which beneficiaries are moving into managed care in the short-term, the majority of beneficiaries will still be in fee-for-service. Therefore, we need to look for ways to improve our purchasing power. Over the past several years, private sector purchasers of health services have developed a variety of innovative ways they pay for health services. It is ironic that HCFA, the largest purchaser of health services in the U.S., has often been shackled by outdated statutory payment and administrative pricing provisions, which prevent us from adapting to today's marketplace.

Beneficiary-Centered Services—Given the pressures on the federal budget, it is critical that Medicare look beyond traditional purchasing strategies and scan the private industry horizon for new ideas. HCFA's "Beneficiary-Centered Purchasing Initiative" proposals do just that, applying lessons learned from the private sector and our demonstrations. With these proposals, we will have innovative purchasing arrangements which will be powerful tools to control Medicare spending now and in the future.

For example, under our "Centers of Excellence" demonstration, Medicare achieved an average of 12% savings for coronary artery bypass graft procedures performed, with no reduction in quality. Despite this success, we do not have the authority to make the Centers of Excellence program a permanent part of Medicare. Similarly, while other purchasers of health care services are successfully using disease and case management services to selectively provide services for enrollees with specific conditions (e.g. diabetes, congestive heart failure), we do not have this kind of authority under Medicare fee-for-service. The Office of Inspector General reports indicate that Medicare is paying far more for medical supplies and DME than other federal purchasers such as the Department of Veterans Affairs. Nevertheless, Medicare lacks authority to use competitive bidding to establish payment rates. I urge Congress to re-examine these issues and give the Medicare program the flexibility to

pay on the basis of special arrangements, as opposed to statutorily-determined, administered prices.

Post-acute Services—Expenditures for skilled nursing facility (SNF), home health, rehabilitation and long-term hospital services are among the fastest growing components of Part A, and, total Medicare spending. These services are often referred to as "post-acute care services," even though in some cases these services are delivered without a prior hospital stay. The increase in expenditures for post-acute care is due to demographic changes and improvements in the delivery of medicine that allow more care to be delivered in non-hospital settings. In addition, our prospective payment system for hospitals provides the incentives for hospitals to discharge patients more quickly, which also fuels the growth in post-acute care spending. Further, discharges to post-acute care providers may cause Medicare to pay twice for care—once for the initial hospitalization, and again for care in the post-acute settings.

The President's budget includes a proposal to end these double payments. We propose to limit the definition of a discharge, for payment purposes, to discharges from the hospital to home. All other discharges, including those to SNFs and rehabilitation hospitals, will be considered "transfers." We are looking to develop better integrated and more flexible financing and delivery systems. These systems will help meet the needs of those Medicare beneficiaries with chronic conditions and disabilities who receive services from these post-acute care providers. The goal is to make the system of services "beneficiary-centered," where the needs of the patient, rather than the classification of the provider, determine what services are provided and how they are reimbursed. In the interim, we will move to prospective payment systems for home health care and SNFs to assert greater control over post-acute spending.

Beginning in July 1998 and phased in over 4 years, we propose to implement a prospective payment system for SNFs, which will include payment for all costs related to SNF care (routine, ancillary and capital). SNFs will be paid a prospective rate per day of care, which will be adjusted by a case-mix index to appropriately reflect the resources used by Medicare patients. A prospective payment system that incorporates all costs will reduce incentives for over-utilization of ancillary costs which has been the primary reason for the rapid expenditure growth we have seen in the past few years.

We are also proposing to implement a prospective payment system for home health agencies (HHAs). Beginning in 1999, we will pay HHAs a prospective rate based upon the characteristics of the patients it serves, not on how many services it provides. Because we cannot continue to allow expenditure growth at current levels, we are proposing to implement additional cost limits until we can implement this prospective payment system. Effective FY 1998, we will reduce the current cost limits and introduce a new per beneficiary per year limit. The Administration is proposing a series of policy changes to prevent excessive and inappropriate billing for home health care services, which are described earlier.

In addition, the Administration is also proposing to reallocate some of the home health financing to Part B to restore the post-acute care nature of Part A. Data from our Medicare Beneficiary Survey indicate that home health care plays a significant role in the ability of many elderly to continue to live at home: 1 in 3 home health users live alone, and 4 in 10 have incomes below $10,000. Under the Administration's proposal, the first 100 visits following a three-day hospital stay would be reimbursed under Part A, just as this program covers 100 days of skilled nursing care following a hospitalization. All other home health care (visits beyond 100 and those not following a hospital stay) would be paid under Part B. Prior to OBRA 80, the Part A portion of the home health benefit was limited in this way. OBRA 80 legislation eliminated the three-day hospitalization requirement and the Part A and Part B visit limits, and in so doing made Part A responsible for almost all of the financing of home health. The restoration of non-post acute visits to Part B makes the home health benefit consistent with the Medicare statute's original intent and its division of services between Part A and Part B.

Contractor Reform—While modernizing our payment methods for purchasing health care services for beneficiaries is an essential step toward modernization, we must modernize the way we purchase administrative services. The President's budget contains a proposal that would end the requirement that all Medicare contractors (that is, carriers and intermediaries) perform all Medicare administrative activities. It gives HCFA the tools to take advantage of innovations and efficiencies in the private sector when it comes to utilization review, beneficiary and provider services, and claims processing. It builds upon the authority granted in the Health Insurance Portability and Accountability Act (HIPAA), where payment integrity activities (such as audits) could be separately contracted. This provision also would allow us to use the same competitive requirements that apply throughout the government

when awarding new contracts, and expand our pool of potential contractors beyond insurance companies to other entities that may be well-qualified to do the work.

2—Modernizing Managed Care Choices

Under our Medicare Choices initiative, we would expand managed care options, provide beneficiaries with comparative information on all of their health care choices, ease comparison among options by increasing standardization of benefits, provide a coordinated open enrollment period and other open enrollment opportunities and institute Medigap reforms. Let me address each of these components separately.

Expanded Managed Care Options—Currently, HCFA can contract with Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to serve as Medicare managed care plans. The Administration believes that Medicare beneficiaries should have more managed care choices, comparable to those available in the private sector. Thus, the President's budget would expand managed care options to include Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs). We believe that direct contracts with alternative managed care models such as PSOs are the key to expanding managed care to rural areas.

Comparative Information—Under current law, beneficiaries may obtain comparative information on Medigap options through State Insurance Counseling Grant Programs. Some of these programs also address managed care options. There are no mechanisms, however, to ensure that beneficiaries are aware of all their options, in both managed care and Medigap. Under the President's budget, the Secretary will develop and provide comparative information to beneficiaries on all managed care plans and Medigap plans in the area. This information will be used by State Insurance Counseling Grant Programs to assist beneficiaries in understanding their coverage options. The costs of preparing and disseminating this information and supporting the State Counseling Grant Program will be financed by the Medigap and managed care plans.

Standardized Benefits—While comparative information will be helpful to beneficiaries, making an informed decision among the array of available coverage options would be hampered unless differences in benefit packages are addressed. Under the President's budget, the Secretary will establish standardized packages for certain additional benefits offered by managed care plans. For example, if the Secretary established a standardized package for outpatient prescription drugs, plans could offer enrollees this benefit only according to the structure established by the Secretary. The development of standardized additional benefit packages will make it possible for beneficiaries to compare these benefits on the basis of cost and quality. The National Association of Insurance Commissioners (NAIC) will also review the current standard Medigap packages to see if changes could be made to ease comparison with the standard managed care benefits.

Open Enrollment Opportunities—Under Federal law, aged individuals have a once in a life-time opportunity to select the Medigap plan of their choice when they first join Medicare at age 65; individuals who become eligible for Medicare because of a disability or end-stage renal disease beneficiaries have no such choice. If a beneficiary enrolls in a managed care plan and is later dissatisfied, he or she may not have the opportunity to select the Medigap plan of his or her choice; for example, drug coverage may be unavailable due to the individual's poor health status. As a result, some beneficiaries are reluctant to try managed care or are fearful of being locked into managed care options with no opportunity to return to fee-for-service and Medigap.

The President's budget gives all new beneficiaries, not just aged beneficiaries, the opportunity to choose the managed care or Medigap plan of their choice when they first enroll in Medicare. In addition, each year all Medigap and managed care plans will have to be open for a one month coordinated open enrollment period. Additional open enrollment opportunities will be available under certain circumstances—such as, when a beneficiary's primary care physician leaves a plan or when a beneficiary moves into a new area. While the concept of coordinated open enrollment is not new and was included in the 1995 Conference Agreement, the key difference in our proposal is the inclusion of Medigap plans.

Other Medigap Reforms—In addition to addressing open enrollment, there are other Medigap reforms included in the President's budget. We would like to eliminate the ability of Medigap insurers to impose pre-existing condition exclusion periods. Under the policy in the President's budget, a Medigap plan cannot impose an exclusion period for a beneficiary who has recently enrolled in another Medigap plan, Medicare managed care, or employer-based plan. This is similar to the policy included in a bi-partisan bill introduced by Mrs. Johnson and others during the last session and we look forward to working together toward enactment this year.

Our final Medigap reform addresses rating. There are currently no federal requirements regarding the rating methodology used by Medigap plans. As a result, plans can use low premiums to entice beneficiaries to enroll in their fledgling stages, but as the company matures it raises the premiums to unaffordable levels. Under the President's budget, Medigap plans would be required to use community rating to establish premiums. The movement to community rating would be subject to a timetable and transition rules developed by the NAIC. Given that managed care plans are required to charge all enrollees the same premium, Medigap plans should not be allowed to charge differential premiums based on age. Also, if choice is an important goal, then premium structures such as attained age rating, which in effect make Medigap unaffordable as beneficiaries age, should not be allowed.

3—Preventive care

One of the core elements of our restructuring agenda is modernization of Medicare's coverage of preventive care. The cost-effectiveness of illness prevention is well-known; in the long run, preventive medicine pays for itself. The President's budget would make some significant improvements in the area of preventive benefits. I would note that there is a bipartisan consensus on many of these proposals as indicated by the similarities between our initiatives and legislation sponsored by Chairman Thomas, Mr. Cardin and Mr. Bilirakis. We look forward to working with you to enact these new benefits:

Colorectal Screening Coverage—Colorectal cancer is the second most common form of cancer in the U.S. and has the second highest mortality rate. Yet, despite the demonstrated importance of early detection, Medicare does not pay for procedures used to detect colorectal cancer when used as a screening tool. The President's budget would provide such coverage, thereby increasing the possibility of early detection and treatment of colorectal cancer.

Mammography Coverage—Forty-eight percent of new breast cancer cases and 56 percent of breast cancer deaths occur in women age 65 and over. For this reason, the early detection and treatment of breast cancer is a high priority for HCFA. Although Medicare covers both screening and diagnostic mammography, only 40 percent of all eligible beneficiaries over age 64 (excluding those in managed care) received a mammogram in the two-year period from 1994 through 1995. In addition, only 14 percent of eligible beneficiaries without supplemental insurance received mammograms during the first two years of the screening mammography benefit, which began in 1991.

The President's budget expands coverage for screening mammograms to provide for an annual mammogram for women age 65 and over. This is consistent with the recommendations of most major breast cancer authorities. The budget also proposes to waive cost-sharing for mammogram services in order to encourage their use.

Expanded Benefits for Diabetes Outpatient Self-Management Training and Blood Glucose Monitoring—The third area where we propose to make investments is in services for beneficiaries with diabetes. Under current law, Medicare covers diabetes outpatient self-management training only in hospital-based programs, and covers blood glucose monitoring (including testing strips) only for insulin-dependent diabetics. The President's budget would expand coverage of diabetes outpatient self-management training to non-hospital-based programs, and expand coverage of blood glucose monitoring (including testing strips) to all diabetics.

Preventive Immunizations—Current law provides payment for the administration of pneumonia, influenza, and hepatitis B vaccines, and already waives payment of coinsurance and the Part B deductible for pneumonia and influenza. The President's budget increases payment amounts for the administration of all three types of vaccines, and waives payment of coinsurance and applicability of the Part B deductible for the hepatitis B vaccine. These measures will improve access to adult vaccinations and make the cost-sharing waiver consistent for all covered vaccines.

4—Beneficiary Protections: Coinsurance Reform and Enrollment Improvements

Reform Beneficiary Coinsurance for Hospital Outpatient Department Services—Coinsurance for Part B services is generally based on Medicare's payment amount. However, for certain outpatient department services (OPDs), coinsurance is a function of hospital charges, which are significantly higher. In addition, as a result of a flaw ("formula-driven overpayment") in the statutory formula determining Medicare's payment for certain OPD services, hospitals have had an incentive to increase their charges. The net effect of charge-based coinsurance and hospitals' increases in their charges is that in 1998, without a change in law, beneficiaries will pay an effective coinsurance rate of 46 percent for OPD services rather than the 20 percent for other Part B services. This effective coinsurance rate is expected to increase to 52 percent by 2007.

The President's budget proposes the establishment of a prospective payment system (PPS) for OPD services in 1999. Total payments to hospitals for OPD services will be established so as to equal total payments that would otherwise apply, minus the effect of the formula driven overpayment. This also assumes the extension of certain OPD policies included in OBRA 93 that are slated to expire in 1999. Coinsurance will be reduced starting in 1999 using the savings from the formula-driven overpayment. It would also be gradually reduced in subsequent years until it equals 20 percent in 2007.

Part B Enrollment and Premium Surcharge—Under current law, with certain exceptions, beneficiaries who do not enroll in Part B when they are first eligible can enroll subsequently only during an annual open enrollment period from January to March of each year, with coverage effective in July. In addition, for each year that they could have enrolled in Part B but did not, they face a 10 percent premium surcharge. While for most beneficiaries the surcharge is in the 20–30 percent range, some beneficiaries face a surcharge of 150 percent or more—an amount which is punitive rather than bearing any relationship to the cost to Medicare of late enrollment.

In recent years, flaws in this enrollment process and inequities in the premium surcharge have become obvious. Beneficiaries who never enrolled in Part B due to availability of other coverage have attempted to enroll after their circumstances changed. For example, beneficiaries may have not have enrolled in Part B because they had generous retiree coverage through their former employers. Years later, however, they were informed that the former employer was now requiring Part B enrollment or was dropping coverage entirely. There are also situations where military retirees did not enroll in Part B because they could obtain physicians' services through a clinic at the military base near their home. Then, years later, the closing of their base necessitated Part B coverage.

The President's budget replaces the annual general enrollment period for Part B with a continuous open enrollment period. Beneficiaries will be able to enroll in the program at any time, with coverage beginning six months after enrollment. Also, the Part B premium surcharge for late enrollment will be revised based on the actuarially determined cost to Medicare of late enrollment. This provision will provide substantial relief to thousands of beneficiaries.

5—Program Improvements

Respite Benefit—The President's budget creates a respite benefit, beginning in FY 1998. This much-needed benefit will provide up to 32 hours of care each year for beneficiaries suffering from Alzheimer's and other irreversible dementia. Respite care may be provided at home or at a day-care facility, and will serve to ease the emotional "burnout" that is commonly experienced by primary caretakers, especially when they are family members. In the spirit of the Administration's efforts to improve the quality of family life, this benefit is an important step toward a community-and family-centered approach to health care.

Social Security Disability Demonstration—Lack of health coverage is often a barrier to the disabled in their efforts to go back to work, since after a transition period they are ineligible to receive premium-free Medicare Part A coverage. The Social Security Disability Insurance demonstration (SSDI) will allow certain SSDI beneficiaries to receive premium-free Part A coverage for up to four additional years.

6—Integrated Quality Management

The President's budget will provide authority for HCFA to develop an integrated quality management system that will unify HCFA's quality assurance activities. Our current quality assurance activities are focused on minimum standards rather than the goal of achieving the best practicable health outcomes for beneficiaries. This new authority will allow us to assess the overall quality of care beneficiaries are receiving, and to require that care be effectively coordinated among different settings, rather than site by site as in our current system. As we move to require managed care plans to assess the overall quality of care they are providing to beneficiaries, we should be able to make the same determinations for beneficiaries who remain in fee-for-service Medicare.

7—Improving Access in Rural Areas

The character of the American experience was formed in great part by frontier and rural communities, yet over the past century we have become a largely urban society. Almost 200 million (75%) Americans live in urban and suburban areas, compared with only 60 million (25%) Americans living in rural areas. This has a profound impact on the type and availability of health care services as advancing technology requires ever more costly medical equipment. Additionally, there is the long-

standing problem of enticing physicians and other health care providers to practice in rural areas.

This Administration continues to promote Medicare reforms that strengthen health care in rural America. For example, our plan will expand the extremely successful Rural Primary Care Hospital program to all 50 states. To ensure that the 10 million Medicare beneficiaries living in rural areas do not become second-class citizens in terms of access to health care, our plan updates the payment for Sole Community Hospitals, improves the Rural Referral Center program, and reinstates the Medicare Dependent Hospital program to provide resources to those rural hospitals that need it most.

Conclusion

We have looked beyond the immediate concerns of budget reductions and sought to keep our sights on the long-term goal, which is safeguarding the vitality of the Medicare program. As our Nation evolves into a society with greater numbers of the elderly and infirm, we must preserve Medicare as a strong and vital program. The President's budget modernizes Medicare, extends the solvency of the Hospital Insurance Trust Fund for ten years, reduces the rate of growth in Medicare spending, and contributes to a balanced budget in 2002. It is essential that we protect Medicare, and our payment reforms and strategies will ensure that Medicare continues to be a sound investment in our Nation's health security for years to come.

Mr. Chairman, many of these reforms are initiatives that you, too, have championed. We look forward to working with you, Mr. Rangel, Mr. Thomas, Mr. Stark, and all the Members of the House Ways and Means Committee to further strengthen and improve the Medicare program.

Modernizing Medicare

Prudent Purchasing

- Centers of Excellence
- Competitive bidding
- Global payment for selected services
- Inherent reasonableness authority
- Post-acute services payment reform

Improving Choices

- Expanded managed care options
- Annual open enrollment for Medigap and managed care plans
- Comparative information on all choices
- Medigap community rating
- Medigap pre-existing condition reform
- Standardized additional benefit packages
- Revised managed care payment

Beneficiary protections

- Hospital outpatient coinsurance reform
- Part B late enrollment surcharge reform
- Improved financial protections for managed care enrollees

New Benefits

- Diabetes education
- Improved mammography benefits with no cost-sharing
- Colorectal cancer screening
- Increased payment for vaccines with no cost-sharing
- Respite benefit for Alzheimer's patients

Chairman Thomas. Thank you very much, Dr. Vladeck.

Just to clarify the record at the beginning, my colleague from California talked about our concern in terms of any increases on

beneficiaries and that the desperately poor are what we need to focus on. I just need to get it straight in my head. I do not know exactly how you define "desperately poor," but obviously, they would be below the poverty level, I would assume, if they are desperately poor.

If someone is a senior and eligible for Medicaid, for example, what out-of-pocket costs are attributed to them in the program?

Mr. VLADECK. For duly eligible, the——

Chairman THOMAS. No—straight Medicaid.

Mr. VLADECK. Are you talking about QMBs? For Medicare beneficiaries who have Medicaid coverage as well, dual-eligibles comprise about 12 to 14 percent of our beneficiaries, and their out-of-pocket health expenditures should be essentially zero.

Chairman THOMAS. So, if they are desperately poor, whatever we do in this programmatic change will not affect them.

Mr. VLADECK. That is correct.

Chairman THOMAS. And there is a group called the SLMBs, which are slightly higher than the QMBs, and it goes up to about 120 percent of poverty. And if we deal with any adjustments on part B, don't they get their part B paid for?

Mr. VLADECK. SLMBs get their premiums paid for, but they do not get the supplemental benefits that folks who are fully eligible for Medicaid benefits would receive.

Chairman THOMAS. Depending upon how you define "desperately poor," if it clearly is below the poverty level, anything we do in any of these programmatic changes will not cost them out of pocket since they do not have any out-of-pocket costs.

Mr. VLADECK. I think that is right, and I think that that is why we seek to emphasize, Mr. Chairman, that——

Chairman THOMAS. I just want to make sure, as we have these great liners about whom we are protecting in terms of changes, that in fact the people whom anyone would define as "desperately poor" are not going to be negatively impacted by anything we do.

Mr. VLADECK. No, sir, and that is why our concern focuses on those who do not meet the Federal definition of poverty, but I believe by anyone's view, they are certainly far from very affluent and are primarily living on fixed incomes.

Chairman THOMAS. That is a fruitful area for working together to make sure these folks are covered. But the "desperately poor" that I just heard about, whom someone is worried about, are already taken care of.

There is a large group of folks we need to be focused on, but I do not think it is the desperately poor, since there is not $1 out of pocket that they are going to be affected by.

Now, let me spend just a couple of minutes on home health transfer, and you may not be able to give me the answer right away, but we do need to understand the impact on both the part A and part B in terms of the transfer.

I was under the impression that if you set aside—since, for budgetary purposes, the transfer does not affect the total reduction that the President's package has of $100 billion over 5, or whatever CBO says OMB's $100 billion over 5 is—if you did not do the transfer, the $100 billion of OMB recognized reductions would extend the trust fund to about 2004.

Now, yesterday, the Secretary said that according to you folks, it is only about 2002; is that correct?

Mr. VLADECK. That is correct.

Chairman THOMAS. And you agree with that?

Mr. VLADECK. That is correct.

Chairman THOMAS. I guess what we need to do, then, is see the particulars of what the assumptions are regarding the baseline on both A and B in terms of rate of growth, because we are going to be asking CBO that question as well. I think there is reasonable room for disagreement on how far we go, and the difference between 2002 and 2004, I think, is quite significant in a timeframe. The administration has staked out a 10-year years-for-years' sake strategy in part, and my concern is, as you well know, primarily on the programmatic change. Since 2004 is the last term of the President who succeeds the current President, that seems to me at least some kind of timeframe that would allow us to continue to look at some changes. If it is only 2002 by your numbers, then we need to partially rethink the way in which we are looking at whether or not years-for-years' sake is, in fact, a strategy that we have to adopt, rather than wanting to adopt, to reach a particular year.

Any of those kinds of assumptions and payouts would be helpful to us.

Also, I do not know if you have calculated it this way, but you have all the numbers, and we do not, and I would very much like to have the answer to this question. You have decided that the part B premium, contrary to current law, will be frozen at 25 percent instead of going down to about 20.8, I think it is, in 2002. If you freeze the premium at 25 percent and carry out your shift of 78 to 82, 2 billion over into the general fund, that will be borne 100 percent by general fund, so it is a new general fund obligation in essence. But you argue that the premium will be at 25 percent. Well, if it is at 25 percent now, and you shift all of that money over to the 100-percent side or the 75-percent side in the distribution, what in essence would be the real burden between the beneficiary and the general fund—because it certainly would not be 25–75. My guess is it is pretty close to the 20.8, or 21 percent that would have been the case if you had left current law in place.

Mr. VLADECK. I do not have that exact number for you, Mr. Chairman, but we have the numbers you would need in order to calculate that, and certainly by the end of the day today, we can get you that number.

Chairman THOMAS. That would be helpful because rather than say that in fact we are putting an extra burden on the beneficiaries as opposed to current law, we are in fact by this switch not obligating them any more on a split than would otherwise be the case if we did not transfer home health care.

Now, one other point in terms of this home health care transfer. You folks have said it from day one when the Secretary held a press conference more than 1 year ago; it was said yesterday, and you have just repeated it again today—that what you are doing is going back to a pre-1980 structure. And I guess what I will say is that the only thing I can recognize as a pre-1980 structure is that there is home health care on the part B side, because as you know,

the part B home health care pre-1980 was part of the premium and the deductible, and you are not proposing that; you are going 100 percent to the general fund. But beyond that, I think I heard you say that in terms of the part A, with the 100 visits, all that is being transferred over to part B will be the current postacute home health care.

Currently, that is being consumed at significantly higher rates by many people than 100 visits a year—in fact, more than 20 percent according to a 1994 statistical layout that you folks were kind enough to provide us. Of those 20 percent who consumed more than 100 visits, the average among those folks was 227.

This is a Social Security Act-related law December 1978, "Part B Supplementary Medical Insurance benefits, section 1831. Section 1832. Scope of Benefits. Home health services for up to 100 visits during a calendar year."

Do you propose to cape the home health care visits that you propose to transfer under part A to part B to make it, as you have repeatedly said, like the structure pre-1980?

Mr. VLADECK. No, sir.

Chairman THOMAS. OK. If this transfer is not part of the premium, is not part of the deductible, and does not limit it to 100 visits how can—well, I know why you say it—how can you continue to say this is like it was pre-1980?

Mr. VLADECK. Because, Mr. Chairman, we think there is a significant difference in the characteristic of the beneficiaries and the characteristic of the benefit between those who are associated with an immediately passed hospitalization, including post-acute services associated with hospitalization and beneficiaries who are admitted from the community into home health services. We think these individuals have different needs, receive different services, and therefore, they should receive different benefits.

With regard to the extent to which similarities outweigh or do not outweigh the differences between what we are proposing and the status of the law prior to 1980, there is a semantic distinction which I would be happy to defer to you on, but I think the basic distinction——

Chairman THOMAS. Dr. Vladeck, I will tell you it is not a semantic difference. The gentleman from California proposed a compromise here that was dollars and cents. The difference between your proposal and the pre-1980 proposal is dollars and cents, number of visits and who pays what reasonable fair share of the program. It is not semantics; it is dollars and cents. It is programmatic.

And if in fact you are going to propose a transfer which will truly be a pre-1980 transfer, then I think a number of people would be more than willing to look at it. But as a pure grab for pure general fund support for the fastest growing area in Medicare today, it is very difficult for us to try to maintain a working relationship when you absolutely refuse to recognize the fundamental dollars and cents and programmatic differences between what was home health care in part B pre-1980 and what you are proposing. Either you recognize those, and we will deal with them, or it is going to be very difficult to try to deal with this part A to part B transfer.

Mr. VLADECK. We would be happy to discuss that with you, Mr. Chairman, and we need to do so, if I can put just one qualifier on that, in the context of moving to a prospective payment system for home health services in which the number of visits becomes less of a driver of payment. But your point is well taken, and we would——

Chairman THOMAS. Absolutely. We had a prospective payment system for home health care as well as SNFs last time, as you did. Neither one is perfect, but we have got to put some kind of an imperfect structure there and then continue to deal with it. And it makes no sense whatsoever that visits are the driver.

Mr. VLADECK. Well, I think we need to have these two conversations together, and we look forward to having them.

Chairman THOMAS. Thank you.

The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman.

Concerning your charts and your discussion on who is old and who is poor and the percentages—I do not want to go into that again—but I want to, if I can, Bruce, summarize some testimony that we will hear in a little bit and see whether you care to comment on it.

Dr. Reischauer is going to tell us the President is prudent to expand the range of choice very cautiously; that under certain circumstances, HMOs, he is referring to here, could result in less and not more choice. He goes on to say that "policymakers should not wait until 2002 to begin ratcheting down the capitated payments made to HMOs. A gradual phase down of possibly 2 percentage points a year should begin in 1998."

Karen Davis is going to tell us that even if enrollment in managed care plans were to expand more rapidly, it would not yield savings to the program. She says, "It makes little sense to overpay HMOs and encourage Medicare beneficiaries to enroll, yet have the program lose money on each beneficiary who enrolls." Further, she says, "Nor has the long-term success of managed care in controlling costs while providing quality care to seriously ill patients yet been demonstrated. Proceeding cautiously and slowly is in order."

Now, the worst probable thing is, she says, "It is important that managed care plans be held to high quality standards." A recent study—this happens to be a JAMA study—finding that health outcomes of elderly patients worsened under managed care compared to fee-for-service care are particularly troubling. There may also be a significant down side to managed care enrollment that requires beneficiaries to change positions. One of the Commonwealth Fund studies suggested that retaining the same physician for a long period of time has had benefits.

Now, this is an area which I think will be discussed a great deal—are we paying HMOs too much? Do you agree with the tenor of what those witnesses will tell us later and what, if any, are the dangers of not cutting HMO payments as the President suggests?

Mr. VLADECK. Well, let me say two things. The first is that, again, on average, we believe we are clearly paying HMOs too much. On the other hand, because of the enormous variation in what we are paying from one county to the next and the variation within one county from one year to the next, the average level of

the payment is not our only problem in this regard, and we need to fix the various pieces of the system simultaneously.

The related issue there, and I think implicit in your question—and it is really very important to us—I personally feel very strongly, and I think this is a fair characterization of the Administration's view, that we believe there needs to be a level playingfield in which the choice by a beneficiary of whether to elect a managed care plan or a fee-for-service arrangement is a matter that is financially neutral from the point of view of the Medicare Program.

And then, over time, beneficiaries will choose the kinds of arrangements that give them the greatest satisfaction and the highest quality. If capitated plans are going to succeed, plans will need to succeed by outperforming the fee-for-service community within the communities.

At the moment, we do not believe the playingfield is entirely level for several reasons, such as the way in which we pay HMOs which is the most significant. On the other hand, we have been very concerned with proposals in the past like many in the 1995 legislation that we thought would tilt the playingfield in specific directions.

The trick in doing this is to really try to achieve a way to save money regardless of the choice the beneficiary makes and to make that choice as open, uncoerced, and beneficiary-driven as we can, and then to let the various kinds of service providers compete on quality and customer satisfaction for enrollment.

Mr. STARK. Just two questions, quickly. Does current enrollment in HMOs cost us more on average than the fee-for-service program, and have you had any indication that the quality of HMO programs of care on average is as good, better, or worse than fee-for-service?

Mr. VLADECK. In answer to your first question, on average, Medicare loses money when people enroll in HMOs as opposed to staying in the fee-for-service sector.

Second, we do have a fair amount of data that on average, the quality of care received by Medicare beneficiaries and HMOs is as good as or better than the quality of care received in the fee-for-service sector.

We have two studies, however—one, the study that you cited from JAMA, and the other, a study done for us by researchers at the University of Colorado—that suggest that particular subcategories of Medicare beneficiaries with significant chronic care or long-term care problems may fare less well qualitatively in managed care plans than they do in fee-for-service.

Mr. STARK. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Before I go on to my other questions, I want to address what you said last because first of all, you were saying qualitatively—is that a scientific study? Are you saying as a matter of fact that HMOs provide worse care?

Mr. VLADECK. I am saying that insofar as anyone——

Mr. ENSIGN. You said "suggest"——

Mr. VLADECK [continuing]. Is able to measure quality of care at the moment, there are two studies—one that looked at specific chronic illnesses, one that looked specifically at postacute care—which are the best studies of those specific subjects currently available, which show that the quality of care provided to Medicare beneficiaries and HMOs in those instances was inferior to the quality in fee-for-service.

Mr. ENSIGN. Do you think the number of senior citizens switching to HMOs—do you think seniors talk amongst themselves, in other words, saying, Hey, do you like your HMO? Do you think that that means anything to senior citizens?

Mr. VLADECK. Oh, absolutely.

Mr. ENSIGN. If they thought they were getting worse care, do you think more and more seniors would continue to switch to HMOs?

Mr. VLADECK. Well, let me answer that in two parts. First, I do not believe this is the case, and second, unless they regularly read the Journal of the American Medical Association——

Mr. ENSIGN. I said talk amongst themselves.

Mr. VLADECK [continuing]. The availability at the moment of good data about that is very limited.

Mr. ENSIGN. No. I was just talking about talking amongst themselves.

Mr. VLADECK. Our data show that most of our beneficiaries enrolled in HMOs are extremely satisfied.

Mr. ENSIGN. The only reason I asked that was because it actually leads to another one of my questions. What percentage have you assumed in your budget will be people who are going to be switching over the next 5 years to HMOs?

Mr. VLADECK. Yes. Our actuaries actually have a very complicated model that models enrollment growth in managed care plans, and they have run the numbers both under current law assumptions and on assumptions of all the proposals in the President's budget.

Mr. ENSIGN. Over the next 5 years under current law.

Mr. VLADECK. Over the next 5 years, and if I can find the page in the book, I will cite those numbers.

Thank you. Good staff work. Our projections are—we are now at about 13 percent. Our actuaries project that under current law, total enrollment in managed care by Medicare beneficiaries in 2002 would be between 19 and 20 percent.

Mr. ENSIGN. OK.

Mr. VLADECK. But that under the President's budget proposal, total enrollment in 2002 would be about 22 percent.

Mr. ENSIGN. OK. The only thing I would suggest that you may be just a little conservative on is seeing what has happened in southern Nevada over the last 2 years. We have gone from pretty high numbers, in the thirties, to now over 50 percent. I would suggest that seniors talk to each other, and they seem to be liking some of the extra services they are getting from managed care. I would suggest that you look at the numbers and, as managed care becomes more available, those numbers might be just a little bit low.

The second question has to do with your chart over here and the 8 to 21 percent. Secretary Shalala yesterday brought the same

chart, emphasized the same chart, and this seems to be like a revelation. That is kind of obvious, isn't it, to anybody with any common sense?

In other words, when you have small children, you have higher health care costs; when you get older, you have higher health care costs; when you have kids going to college, you are going to have higher education costs. Seniors have lower housing costs, is that not correct—as a percentage of their income?

Mr. VLADECK. OK, but again, we are talking about—and here is the distinction which I think is important—we are talking about what Medicare insurance—this is only the out-of-pocket cost——

Mr. ENSIGN. Yes, I know. I know that. I know that. What I am saying is that at different stages of your life, your market basket is made up of different things. When you have small children, you go to the doctor more.

Mr. VLADECK. That is correct.

Mr. ENSIGN. OK. When you are older, you go to the doctor more. When you are going into college, you have higher educational expenses. At certain times, you have higher housing costs, you have higher car costs, you have whatever. Seniors have a tendency to have lower automobile and lower housing costs.

The point I am making is that that chart is meaningless.

Mr. VLADECK. Well, I would disagree for the following reasons, sir——

Mr. ENSIGN. Well, let me put it this way. It is obvious; without doing any research, that is an obvious chart.

Mr. VLADECK. But let me make one suggestion that 8 percent for people under the age of 65 is relatively constant, regardless of family age or family structure for insured people.

Mr. ENSIGN. Sure.

Mr. VLADECK. That is to say, for Americans with health insurance, the out-of-pocket proportions tend to be the same throughout the life cycle until they get to Medicare, at which point the limitations on the benefit compared to private health insurance cause that number to shift.

Mr. ENSIGN. Well, it also might be that they get older, and they do happen to get sicker as they get older.

Mr. VLADECK. That is absolutely correct.

Mr. ENSIGN. The last question, since Mr. Stark went over, if I may indulge the Chairman——

Chairman THOMAS. The gentleman will yield.

Mr. ENSIGN. Yes.

Chairman THOMAS. That is not why you are getting the extra time.

Mr. ENSIGN. Oh. Thank you.

Chairman THOMAS. It is because the Chair is indulging you.

Mr. ENSIGN. Thank you, Mr. Chairman.

The other question I would ask quickly is that I have noticed—and this question was brought up yesterday—that your plan does not address any kind of medical malpractice reform. Does the Administration feel there is not a problem?

Mr. VLADECK. I do not know that we have an official position. I do think we do feel that——

Mr. ENSIGN. Do you as an individual?

Mr. VLADECK [continuing]. Our Social Security Act is not the vehicle through which to address problems of the tort system.

Mr. ENSIGN. As somebody who is an expert in the health care field, do you feel there is a problem in the whole idea of malpractice insurance and malpractice lawsuits?

Mr. VLADECK. Let me narrow my answer if I may, because I have a lot of lawyers in my family. Having looked at this issue for many years, I do not believe that either the direct expenses associated with the malpractice system nor the phenomenon of defensive medicine is a significant contributor to the cost of health care compared to the cost of liability risks in most other enterprises in this society.

Mr. ENSIGN. So——

Mr. VLADECK. I do not believe that the absence——

Mr. ENSIGN. I guess you have not talked to the same doctors I have talked to, because the doctors I talk to—and it has even trickled down to poor, old veterinary medicine—that we experience the same kinds of things. I would just spend some more time talking to doctors.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman from Nevada. I guess what the gentleman from Nevada was saying is that we believe the chart would be much more useful if you had 100 percent of income on the under 65, 100 percent of income and what their out-of-pocket costs are for various activities, and I think it would be self-evident that the gentleman from Nevada's point would be made that there are different costs in different stages of life.

It still does not change the fact that that is the portion for the seniors, but that in fact there are differences in terms of what occurs to people in different phases of life. That does not give you as much information as you would like, and I understand I gave you the information that you would like.

Mr. VLADECK. We would be happy to try to determine that for you. I do not know that HHS maintains that——

Chairman THOMAS. No. It would be from somebody——

Mr. VLADECK [continuing]. But BLS does, I believe, or Commerce, and we will try to track it down.

[The information was subsequently received:]

Response to the House Committee on Ways and Means, Subcommittee on Health Consumer Spending Patterns of the Elderly Compared to the Non-Elderly

On February 13, 1997, HCFA Administrator Bruce Vladeck noted in his testimony to the Subcommittee that the elderly spend 21% of their income on health care, compared to 8% spent by the non-elderly. The Subcommittee asked the Administrator to provide similar information on the percent of income spent in other areas, such as housing, transportation, food, etc.

The data on the percent of income spent on health that was presented by the Administrator was based on an analysis conducted by Marilyn Moon of the Urban Institute, which used data from the **National Medical Expenditure Survey (NMES)**. NMES is the most recent, comprehensive database that contains individuals' expenditures for health care services, including age-specific information. The study trended forward the existing 1987 data to estimate out-of-pocket health care spending in 1995 for the non-institutionalized elderly population. Total elderly out-of-pocket spending included Medicare cost-sharing for deductibles and coinsurance, premiums for private insurance and Medicare Part B, and non-covered goods and services including balance billing. Not included in this analysis are the health care costs of the institutionalized population and indirect payments toward health care financing (e.g., federal and state income taxes, property taxes, and Hospital Insurance taxes).

However, in order to respond to the Subcommittee's question about spending in other areas, we must use a different data source, since NMES only collects information on medical expenditures. One of the best sources of data for this information comes from the **Consumer Expenditure Survey** (CES), which is administered by the Bureau of Labor Statistics. The Consumer Expenditure Survey collects information from the Nation's households and families on their buying habits, including data on their expenditures, income, and demographic characteristics.

Differences between NMES and CES analyses

There are important differences between the two surveys regarding their ability to examine the question of the percent of income spent on health by the elderly. One difference is that the Urban Institute/NMES analyses use an individual record approach and CES data are shown using aggregate levels. In the NMES analyses, the actual share of income spent on health is calculated for each individual household, and average household spending on health as a percent of income equals the weighted average of these individual shares. Each household's estimated share counts equally in this approach so that, when averages are calculated, they are more representative of the typical household. This approach was used with the NMES data and was intended to more closely reflect the experience of the average elderly household. However, the method to calculate the shares using the CES data is to use aggregate analyses of spending and income; that is, for the elderly as a group, total aggregate health spending is divided by total aggregate income. This is the accepted method used by the Bureau of Labor Statistics, and is necessary to use here primarily because the CES has a small sample size which does not reliably support the individual record approach. However, when calculating averages using aggregate spending and aggregate income, extraordinary values, such as very high incomes or very large

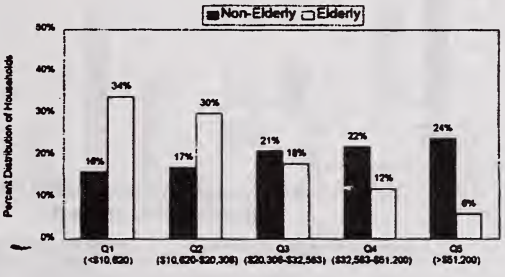
expenditures, disproportionately influence the results. Again, for the purposes of responding to the Committee, we need to use the Consumer Expenditure Survey to look at consumer spending across all categories.

Because of the methodological and sample design differences between the two surveys, the absolute numbers (for shares of income spent on health) will be different, but the trend remains the same: overall, elderly households spend three times as much of their income on health than non-elderly households. In addition, both surveys show that, whether elderly or non-elderly, lower income households spend a higher percentage of income on health care than higher income households.

CES Data: Spending by Income Quintile

Although the economic status of the elderly as a whole has improved significantly over the past thirty years, many elderly continue to have very modest incomes. Nearly three-quarters of all elderly Medicare beneficiaries have incomes below $25,000[1]. In order to get a more comprehensive picture of consumer spending by the elderly and non-elderly, it is useful to group the population by income categories. The Consumer Expenditure Survey data presented here is grouped by income quintile. To compute quintiles, all consumer units[2] were ranked by income, then split into two age groups, elderly (65+) and non-elderly (<65).

Distribution of Elderly and Non-Elderly Households by Income Quintile,1995



Elderly households are those where the reference person is 65 years or older; non-elderly households are those where the reference person is under 65 years old.
Source: Health Care Financing Administration: Data from the Consumer Expenditure Survey

[1] Source: HCFA Office of the Actuary: Medicare Current Beneficiary Survey: Income represents total gross income, and includes pensions, Social Security Railroad Retirement and disability payments; the cash value of food stamps and public assistance payments; capital gains, annuities, VA and Workers' Compensation benefits; interest, dividends, and work-related income. The MCBS collects data on the income of the beneficiary, and spouse, if applicable.

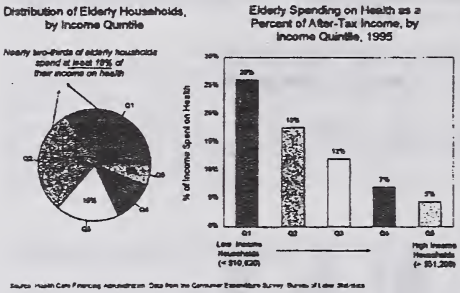
[2] Income is based on total after tax income. Elderly households are "consumer units" in which the reference person (e.g., the person whose name in on the mortgage or lease) is age 65 or older, and so the household may include some people under age 65. Similarly, non-elderly households are "consumer units" in which the reference person is under age 65.

In 1995, the first quintile (lowest income) included households earning less than $10,620; the second quintile, $10,620-$20,306; the third quintile, $20,306-$32,583; the fourth quintile, $32,583-$51,200; and the fifth quintile, more than $51,200. Nearly two-thirds of elderly households were in the two lowest income quintiles (that is, had incomes under $20,306), compared to only one-third of non-elderly households. (Note: This income distribution for the elderly is comparable to the data from the Medicare Current Beneficiary Survey.)

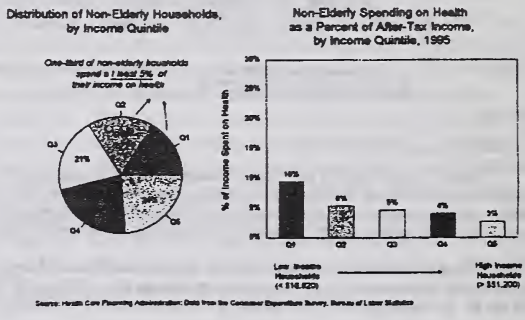
The CES data show that elderly households spend a greater proportion of their income on health than the non-elderly. In addition, the burden of health spending on the elderly has risen over time, but has remained relatively flat for households headed by people under age 65.

Whether elderly or non-elderly, lower income households spend a higher percentage of their after-tax income on health care than higher income households. However, income differences are starkest among the elderly. The poorest elderly households spend a much higher percentage of income on health than those in the highest income quintile: 26% compared to 5%. In contrast, among non-elderly households, the share of income spent by those in the bottom income quintile is 3 times higher than the share spent by those in the highest quintile: 10% vs. 3%.

The poorest elderly households spend 26% of their income on health



The poorest non-elderly households spend 10% of their income on health

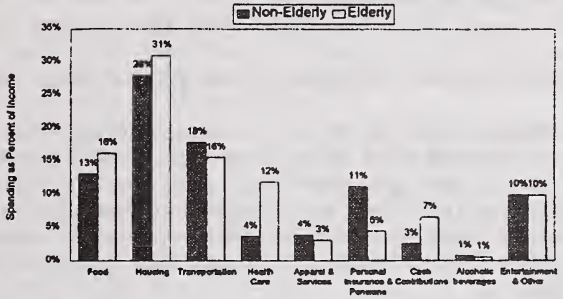


Other Consumer Spending as a Percent of Income

Although the greatest difference in spending between the elderly and non-elderly is on health care, **food, housing and cash contributions**[3] also absorb a greater proportion of their income than the non-elderly. The elderly spend only a slightly smaller proportion of their income on transportation and clothing than the non-elderly.

The only category of spending where the non-elderly spend a significantly greater proportion of their income that the elderly is called "personal insurance and pensions." This includes life and other personal insurance as well as pensions and Social Security. Clearly, most elderly are no longer contributing (or "spending") to Social Security or pensions -- instead, it could be argued that they are drawing down on these resources to meet the demands of rapidly growing health care costs.

Consumer Spending as a Percent of Income
Elderly vs. Non-elderly, 1995



Note: This chart shows spending as a percent of income; therefore, within each group, the percentages may not add up to 100%. That is, some families in a given year may not spend all their income, and some may spend more than their total income as reported on the survey.

Source: Health Care Financing Administration; Data from the Consumer Expenditure Survey, Bureau of Labor Statistics

[3]Cash contributions include cash contributed to persons or organizations outside the consumer unit including alimony and child support, care of students away from home, and contributions to religious, educational, charitable, or political organizations.

Chairman THOMAS. The gentleman from Nebraska is recognized for an indulgent 5 minutes.

Mr. CHRISTENSEN. Mr. Vladeck, the President has proposed in his budget the diabetes prevention benefits similar to our bill last year, H.R. 15. I was surprised to see in OMB's scoring on the President's budget that it was actually going to cost $1.4 billion.

We were under the impression last year, when we passed the Medicare Prevention Benefit Improvement Act, that it actually would result in a savings, and I was wondering if the savings in your analysis of the budget that the President has proposed is going to come in the outyears, or was it actually going to occur sooner than that, so we can have a better understanding of where the President is coming from on diabetes prevention.

Mr. VLADECK. I believe, Mr. Christensen, that this is the case. I believe our actuaries estimate that—actually, I am sorry—I am corrected by my staff. We do have a disagreement between OMB scoring and CBO scoring on this benefit.

Mr. CHRISTENSEN. What is that?

Mr. VLADECK. Again, CBO has not scored this year's proposals. I do recall—you are absolutely right—that last year, if I remember correctly, CBO suggested that the first couple of years of the benefit would cost money, but then it would begin to generate savings.

Our actuary has scored it as a very modest increase in cost, something on the order of $600 million, if I am reading my chart correctly, over the 5 years of the budget.

Mr. CHRISTENSEN. CBO, or——

Mr. VLADECK. No. That is the OMB scoring. We do not yet have CBO scoring of this year's proposal.

Mr. CHRISTENSEN. So, $1.4 billion over the 5 years in terms of cost?

Mr. VLADECK. No. We estimate about $600 million in cost over the 5 years.

Mr. CHRISTENSEN. OK. It was my understanding that OMB had scored these as costing $1.4 billion over the next 5 years. Do your projections show a savings anywhere, and why not a savings? It was my understanding when we proposed it last year, and this is the reason why I think the President is proposing it this year, that there would actually be a savings through this diabetes prevention; isn't that right?

Mr. VLADECK. Mr. Christensen, I cannot speak to CBO scoring either this year or last year; I can only tell you what our actuaries have done, although I cannot tell you why. But I will tell you that I am personally convinced that over a long enough period of time, this benefit will save lives and save enormous human misery. And whether it is a slight coster or a slight spender, quite frankly, is the least of the issue to me.

Mr. CHRISTENSEN. Well, I guess my point is—and I would agree with you, I think it is going to save lives, and I think it is going to save money—but I do not understand how these actuaries sometimes work, and I thought maybe you could enlighten me.

Mr. VLADECK. I am afraid only within limits. I think part of the issue as I understand it—and I do not want to overspeak for them, and we would be happy to get you further information—as I understand it, many of the benefits from this program are anticipated to arise from early interventions for which the benefits in terms of reduced expenditures for eye disease or for coronary complications and so forth are way out into the future. But again, that is a layman talking about this, and we will try to get you some more information on the issues of scoring.

[The information was subsequently received:]

Over time, the diabetes prevention benefits will save lives and save enormous human misery. According to HCFA's estimation of the President's 1998 budget proposals, the diabetes prevention benefits program's projections are: Fiscal 1998 a cost of 0.2 billion; fiscal 1999 a cost of 0.3 billion; fiscal 2000 a cost of 0.3 billion; fiscal 2001 a cost of 0.3 billion; fiscal 2002 a cost of 0.3 billion; fiscal 2003 a cost of 0.4 billion; fiscal 2004 a cost of 0.4 billion; fiscal 2005 a cost of 0.4 billion; fiscal 2006 a cost of 0.4 billion; and fiscal 2007 a cost of 0.4 billion. Totals: 5-year total is a cost of 1.4 billion, and the 10-year total is a cost of 3.1 billion.

Mr. CHRISTENSEN. I have one other quick question. Last year, we had an opportunity to use outside accrediting boards to survey, certify, and propose some of the guidelines for nursing homes. Frankly, some of those outside certifying boards use tougher standards than HCFA has used. What is your position on this, and do you see HCFA moving more toward using outside accrediting boards, or are we going to keep it in-house?

Mr. VLADECK. Let me phrase that question into two, if I may. Our 1996 appropriations accelerated the process for recognizing such—the term we use is "deeming"—such outside agencies for everything but nursing homes. Since that law was changed, we have had new private agencies deemed for ambulatory surgical centers, but we have not seen any great rush of volunteers.

On nursing homes specifically, we owe the Congress a report by July 1 of this year as a result of that appropriations bill, which will review the whole issue of private accreditation of nursing homes. We will meet that deadline. I cannot yet tell you everything that is going to be in the report, but we will have a report to Congress by the end of June on that subject.

Mr. CHRISTENSEN. I am out of time. Thank you, Mr. Vladeck.

Chairman THOMAS. The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman.

Dr. Vladeck, welcome. Following up just very quickly on Mr. Christensen's point, it is difficult for us to understand the dramatic changes in some of the scoring between last year and this year, the diabetes test being one. We understand we do not always agree with the actuaries, but it is disheartening to see such a radical shift in a 1-year period, and I would also appreciate seeing some of those projections of how they were arrived at.

I also want to compliment you on the emergency care within Medicare, using the "prudent layperson" standard, your recommendation to do that. That is certainly encouraging.

I want to talk a little bit about the home health care switch. Secretary Shalala was here yesterday, and I certainly agree with her point that we do not want to increase the burden on our seniors as far as their already high out-of-pocket costs, and I also understand the shift of the home health care services into part B and believe that makes sense.

But I am wondering whether there would not be a more efficient way to deal with the out-of-pocket costs of our seniors, and rather than take the home health care cost out of the part B premium, couldn't there be a more efficient way to deal with those seniors who have high out-of-pocket health care costs or lower income and use that money in a more directed way than to just change the policy and reduce the premiums for all our seniors?

Mr. VLADECK. Let me attempt to respond to your question, Mr. Cardin, and if this is not totally responsive, I am sure you will let

me know. The general issue of the relationship of total out-of-pocket expenditures, premiums, deductibles, copayments, to income and use of services is very close to the other question that has been raised by Members on the other side of the Hill with us yesterday about whether the general structure of deductibles and copayments in the Medicare Program in the aggregate makes any sense. Deductibles and copayments were grouped together in 1965. These structures originated in two very different sets of proposals.

I do believe that—and I know that Dr. Davis, among others, has advocated for a long time that we rationalize the whole structure of copayments, deductibles, and coinsurance within the Medicare Program. This approach would also permit us to consider the relationship between income and beneficiaries' ability to pay.

We would support careful consideration. Let me just conclude my response very quickly by putting in a plug on my favorite subject. At the moment, we could not—the Health Care Financing Administration, Department of Health and Human Services—could not administer such a revised program because we do not have the data processing capability to merge A and B data. When MTS, Medicare Transaction System, is up and running very early in the next decade, it will be technically possible to do this much more easily. It would probably be good public policy to move in this direction.

Mr. CARDIN. Yes. I understand that, and I understand the problems there. I would just urge you to consider, as well intended as the policy is to keep it out of the premium base, that that could become a difficult or dangerous precedent for the future as we look at modifications in the Medicare system, if we start going down that road of saying it is not part of the premium base.

I would urge us to try to look at other ways to deal with our seniors and out-of-pocket costs.

I would make one point. If we do not make this transfer, the amount of cuts that would be necessary to achieve the type of solvency in the Part B Trust Fund would be significantly greater. Have you analyzed what you would have to do if you did not make this transfer?

Mr. VLADECK. We have not analyzed it in detail because, as you know, part of the problem with trust fund solvency is not only the 5-year aggregate, but it is the year-by-year effect.

I would say that the simple rule of thumb here is that our proposed reductions in part A spending in the President's budget over the 5-year period are about $78 billion. The proposed reduction in part A outlays due to the reallocation of home health over the same period is about $82 billion.

In order to get the same trust fund effect of transfering the home health expenditures, you would need to roughly double the level of part A provider cuts that are called for.

Mr. CARDIN. And what impact do you think that would have?

Mr. VLADECK. I think that would then be very significant. We are talking about $60 billion for hospitals over a 5-year period of time. Again, these are rough numbers which are not precise. We are talking about almost $30 billion in cuts in payment to home health agencies over a period of time. We are up into the 25- to 30-percent range in reductions at the end of the budget window, which gets us to a level of reduction that would cause me very great concern.

Mr. CARDIN. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. If the gentlelady from Connecticut would yield for just one moment, Dr. Vladeck, I appreciate the questions and answers that just went on, but this is a direction that now appears to be a strategy rather than a series of questions from various individuals.

If we are going to go forward on a bipartisan basis, you cannot take credit for the policy changes that have been put in place and brag about how you do not have to find as much money because of what has already been done, then propose policy changes and look forward and not take those into account by doing more of the policy changes which will produce a shorter path that we need to travel. But rather build these strawmen about how much has to be done. If that is what you are doing, that is a clear condemnation of the President's plan because it is just years-for-years' sake and dollars for dollars' sake to buy those years and not heavy enough on programmatic changes.

One of the reasons I am concerned about how many years we get without the transfer is that if we do have 6 or 8 years, and we get serious about policy changes—if you have seen that new commercial on television about surfing the web, where the highway turns into a wave, and it rolls—we will have a policy wave in front of us that will buy us those years that you folks just, in a very partisan way, cutely talked about the massive cuts that would have to be made.

If we quit talking about cuts and start talking about policy changes, then you are going to have that programmatic wave in front of you, and it will buy years on a year-by-year, policy-change basis.

If you continue, every time we are sitting in on these hearings, to build these strawmen about how much we are going to have to cut, then I am going to start talking about how much you are condemning the President's program, because there is not enough policy change to build the ability to move forward on change.

We are trying to force a policy change so that we can do just that—make sure we do not have to find as many cuts in the future. If you are just cutting for cutting's sake to buy years, which is what I believe the transfer is, then there is no question the dialog you just had is a reality. But, it is a reality because of the President's program and the failure to find policy change rather than the kinds of cuts you are talking about.

Let us rededicate ourselves to finding those policy changes that will negate the necessity for this kind of partisan strawman building in terms of phoney arguments about what cuts are going to occur in the future. OK? [Laughter.]

Mr. VLADECK. I was just trying to be responsive to a question from the gentleman.

Chairman THOMAS. I understand you were trying to be responsive, and I want to put it in the context in which we are going to deal with those kinds of questions and those kinds of responses.

The gentlewoman from Connecticut.

Ms. JOHNSON. Mr. Vladeck, thank you for being here this morning. Your testimony combined with the Secretary's testimony yes-

terday raises many, many questions. This is an extremely important year for Medicare, and our work together has to be very fruitful. We have lost 2 years on the project of making Medicare sound, so we have made our problem more complicated; and indeed if we fail this year, it will be a catastrophe for the seniors of America.

I would simply point out in followon to my Chairman's comments that in the Republican bill—and I think this is really important, the context—in the Republican bill, we tried to provide very generous premiums so that we would encourage the competition of the private sector, offering better benefits than Medicare offers, and then we slowed the rate of spending growth by slowing the rise in those premiums and in other reimbursement rates, and we did it gradually.

Now, I think that that is very, very important because in your proposal, you are proposing very significant changes in the reimbursement rates for HMO risk contracts. In fact, of your $100 billion in savings, $34 billion comes from the changes in reimbursement rates for Medicare risk contracts, and yet only 12 percent of Medicare beneficiaries are in those contracts. You are hitting that sector of the Medicare delivery system disproportionately. In fact, as I would describe it, you would dramatically alter the Medicare payment method for HMOs.

Have you done the county-by-county analysis? When will we know the county-by-county figures?

Mr. VLADECK. I would hope, Ms. Johnson, that we would have the county-by-county figures for you next week. We have a preliminary run, and we are doing the proofreading and validity checks on those now.

Let me commit that if we do not get them by 1 week from today, by the very beginning of the following week, you will have them.

Ms. JOHNSON. Yesterday, the Secretary said that the aggregate reduction would be about 5.3 percent. I just want to point out the depth of my concern. In 1995 the rate in King's County, New York, would have decreased by $124, or 19.2 percent, per member per month if teaching and DSH payments were removed. Now, it is one thing to take away direct teaching payments for the purpose of reformulating how we fund medical education, but DSH payments are another issue. That would have been a $1,488 reduction per year for each DSH beneficiary enrolled in an HMO risk contract.

Mr. VLADECK. Ms. Johnson, our proposal would prevent that. Under our proposal, no county in the year 2000 will receive a reduction in its rate of more than 3 percent, and in the other years of the budget window, no county may receive a reduction from one year to the next at all. So——

Ms. JOHNSON. Wait 1 minute. The Secretary said yesterday that the reimbursement rates to HMO risk contracts would be cut 5 percent. I consider that a reduction.

Mr. VLADECK. Yes, ma'am, but we also have on all the other things—this is complicated because of all the things going on at once—but we cut the national rate on average by 5 percent, we are phasing in this geographical shift, so there is an offset associated with that, and the way the bill is constructed, in 4 of the 5 years, none of the rates in any county will go down. In the year 2000, the

rates in a number of counties will go down as much as 3 percent, but not any more than that.

Ms. JOHNSON. But you are saying that until the year 2000, the rates will not go down?

Mr. VLADECK. That is correct.

Ms. JOHNSON. I do not understand how the rates cannot go down, and the Secretary can say the rates on average will go down 5 percent.

Mr. VLADECK. The rates in the year 2000 will go down——

Ms. JOHNSON. No, no. She said the HMO risk contracts starting this year will be reimbursed at 90 percent instead of 95 percent. That is a 5-percent cut. Then, in the year 2000, additionally and on top of that, there will be a 5-percent reduction, and if the budget does not balance, 2.2 percent on top of that.

Mr. VLADECK. No——

Ms. JOHNSON. Under nothing the Secretary said yesterday was there any indication at all that there would either be a hold harmless or any freezing of current rates, and in fact if you apply her formula to Cook County, Illinois, the 1995 rate would have decreased by $51 or 10.4 percent per month per member.

I do not know how you can tell me it is not going to go down, and you are going to hold everybody harmless and make the savings that the Secretary said you are going to make because you are going to reimburse at 90 percent instead of 95 percent.

Mr. VLADECK. Well, let me just suggest that, again, on a year-to-year basis, all other things being equal, the rates go up by the average rate of increase in fee-for-service costs.

Ms. JOHNSON. I hear what you are saying, I hear what you are saying. You are saying rates are not going down because the rate is going to stay the same; you are just going to take medical education and DSH out of it.

Mr. VLADECK. No, it is more complicated than that, Ms. Johnson. There are four things going on simultaneously. We have a phased renewal of the medical education and DSH components. We have the geographic equalization and the application of the floor, and we have the reduction in the year 2000 from 95 percent to 90 percent of AAPCC.

Ms. JOHNSON. OK, let me just stop you right there.

Chairman THOMAS. Let us hear the fourth one; what is the fourth one?

Mr. VLADECK. And the fourth one is we have the hold harmless built into the formula as well.

Ms. JOHNSON. Now, wait 1 minute, wait 1 minute. This is unbelievable. You cannot hold harmless if every factor in your formula hits the—Connecticut has some of the poorest cities in the Nation, with big DSH payments. You take away the teaching hospital component from the nonteaching hospital, but one that still serves poor people; you phase out the DSH payment; you do the equalization, which is going to hurt New England because New England is high cost—we get, by your standards, overreimbursed, so we are going to get a cut under that—and I have forgotten the fourth one, but that will hurt us, too. What is the fourth one, again?

Mr. VLADECK. The overall reduction in the AAPCC.

Ms. JOHNSON. Oh, yes, the AAPCC; that will hurt New England. Do not sit there and tell me you are going to make these four changes and save the money from them, but you are going to hold us all harmless. We will get into this in more detail, I am sure, as we go forward, but I can tell you——

Mr. VLADECK. We would be happy to walk through the illustration in any particular county with you.

Ms. JOHNSON. OK. Your answers raise far more questions than they answer, and I will just remind you that we did do the calculation for two of the Nation's biggest innercity hospitals, and the result was a 10.4-percent cut in rate in one and a 19-percent cut in rate in the other, and that is just for starters; that does not reach 2000.

Mr. VLADECK. But we have looked at these for the Bronx, Ms. Johnson, which is very close to my heart, and the fact is that if you apply all of the provisions in the bill over the 5 years of the budget, the Bronx receives about one-half the rate of increase that it would under current law, and still the payment rate in the year 2002 for HMOs in the Bronx is higher than it is in 1998 under our proposal, and we would be happy to walk through all the specifics of that with you.

Ms. JOHNSON. We will certainly have to walk through those details, because the way the material is presented in your testimony and what was referred to by the Secretary does not indicate any of those facts to be true.

I also want to go back to the contrast between the way we dealt with the need to slow the rate of growth. Remember, the First Lady sat here in this very room and testified in 1993—we are now into 1997, 4 years later—to the effect—and she was absolutely right, and to her credit and to the President's credit, they both got out there and talked about this when they were, frankly, young, naive, and I guess more honest—but she sat there and said we have got to slow the rate of growth in Medicare.

Now, the best way to do that for the system is gradually but firmly. In your budget, a third of your savings comes in the very last year, 2002. Now, you know us well enough to know that we cannot save one-third of the savings in the last year. It is not possible. So you are bankrupting Medicare. Don't you get it? You can't put out a program that is not going to save Medicare for America's seniors. And when—we have to win this time. We lost 2 years. It was 4 years ago that the First Lady sat here. We have got to be honest this time, and one-third of the savings in the year 2002 is not honest.

Let me go to some more particulars——

Mr. VLADECK. Ms. Johnson, may I say something to that point?

Ms. JOHNSON. Yes.

Mr. VLADECK. If you take a program that is growing at a rate of 8 to 10 percent a year, and you take level cuts across the 5 years, you will get more than 35 percent of your savings in the fifth year. That is the simple arithmetic of the way we do budget scoring and the way that savings work when you are saving off a growing baseline.

Ms. JOHNSON. I hope you are right, and I certainly would be open to the figures because this is real, we have got to get it right this

time, and we are going to have to spend a lot of hours in the seminar form so that we really do understand it.

Off the top of my head, I am disappointed in my mind and heart. I intend to work with you to get a good plan that I can be proud of and you can be proud of, and we can tell our seniors we put this program back on track.

I have some specific questions, but there will be another round.

Thank you very much.

Chairman THOMAS. Thank you.

Dr. Vladeck, I think this underscores the fact that we need the legislative language as soon as possible. You were able to cite the Bronx in terms of the adjustment of the four categories that you named; we are not. And I am not going to hold these hearings so you guys can go back and change your program to try to make sure the errors that may be in it, at least the ones we have touched on, will be corrected by the time we get it.

I will tell the gentlewoman from Connecticut that what she does not understand is, and what I believe we will find in the legislative language is, that all the subtractions occur and then, after those subtractions occur, there is a hold-harmless provision that is put in for the rest of the time. In other words, after the furniture is removed, after the house has burned down, then the policy kicks in in terms of a hold harmless. If that is not the case, then we certainly need to see the legislative language, because if you have four separate components interacting from day one, we have got to look at the legislative language to understand it. It will save both of us a lot of wear and tear as we try to maintain the bipartisan cooperation as we go forward, because listening to you, we do not understand what you are proposing. Give us the legislative language, and then we can have a more fruitful discussion.

Mr. VLADECK. As soon as we can.

Chairman THOMAS. I understand.

The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman.

Dr. Vladeck, before I get into some of these areas that I want to talk about, I want to compliment the administration for coming up with a plan that does have some tough decisions in it—it was not easy for you to create this proposal—so in some respects, I think we should say thank you for at least coming forward with some specific proposals to create savings in the Medicare Program.

Having said that, let me address the malpractice question for just a second. I do not want to let your characterization of malpractice costs in the system be the final word here because I think you are seriously in error.

I am a lawyer, and I certainly am in favor of a strong liability system in this country. However, I think the way the liability system in this country is currently structured, particularly with respect to the health care field, it lends itself to some mischiefmaking, and mischiefmaking in the health care field leads to higher costs.

Now, you say that you do not personally believe it is a significant factor in rising health care costs. You may or may not be correct. There are those who disagree with you. Two studies have recently been included, in fact, say just the opposite. The American Acad-

emy of Actuaries studied specific reforms in States and found that in those States that have undergone serious medical malpractice reform, the malpractice liability premiums are significantly less than those States that have not undertaken those reforms.

Also, David Kessler and Mark McClellan of Stanford University recently concluded a study in which they also looked at States that have undertaken medical malpractice reforms and found that indirect costs in those States have been significantly less than in States that have not undertaken medical malpractice reform. In fact they conclude that the Medicare system in this country could save up to $600 million a year on heart disease alone if we put reforms in place.

I think there is significant evidence out there that your conclusion is in error, and even if it is not a big cost driver, it certainly is a cost driver. And if we are going to solve the problem of escalating health care costs in this country—and I think we ought to try to do that as best we can, and it is so complex that none of us really want to try to get our arms around it—but we are going to have to try, and if we are going to do it, we are going to have to attack not only the big cost drivers that we all agree on, but maybe some of the less significant cost drivers. We are going to have to do the whole thing.

I would encourage you to take another look at your family members' opinions on medical malpractice reform.

Next, I just want to say a word—and it has been beaten to death, I guess—on the premiums and the shift from part A to part B. I really encourage—and I asked the Secretary yesterday—I really encourage you to take a second look at your decision not to include those costs in the calculation of part B premiums. The financing structure of Medicare is not perfect, but at least it does instill some sense of discipline in the system. You do have some recognition of the costs on the part of seniors because of their out-of-pocket costs and because of their premium costs, and to the extent that you lessen that, you are going to lessen this panel's ability and future Congress' to control costs.

And just out of curiosity, have you figured out what the premium increase would be if you included those costs in part B, in the calculation?

Mr. VLADECK. Yes, sir, we have.

Mr. MCCRERY. What would that be? What would it increase the premiums?

Mr. VLADECK. I have to find the right piece of paper here. In 1998 it would be an increase in the premium of about 18 percent, or about $8.50 a month, $100 per year, roughly. In 2002 the percentage would come down, and there would be an increase in the premium of about $11 a month, or about $120 per year per beneficiary.

Mr. MCCRERY. OK. Thank you.

I agree with Mr. Cardin that rather than just take a blanket approach, maybe we ought to look at some specific way to help those seniors who are on the edge of poverty. I think that that would be a much better approach to solving their problem.

Mr. VLADECK. I think I have heard that message from both sides.

Mr. MCCRERY. Good. One last question on the matter of graduate medical education. As you know, we proposed last year to essentially go to a broad-based financing structure for graduate medical education. Does your administration proposal include anything on that?

Mr. VLADECK. We do not, sir, very frankly, because we have not been able to identify in the context of this year's budgetary process a source of contributions which is a more broadly based mechanism than Medicare's payments.

We continue to believe that in principle, the kind of trust fund which emerged from this Subcommittee and was included in the 1995 legislation, has a lot to be said for it as part of the long-term approach to financing graduate medical education. There are a number of issues associated with the trust fund that will still need to be worked out and I think are very troublesome, but the real issue in the accounting sense is not the uses part of the trust fund design, rather it is the sources part. We have not in the current environment, other than what Medicare is now spending, been able to identify other sources of revenue for this trust fund, and therefore, have not proceeded with a proposal along these lines.

Mr. MCCRERY. Generally, though, do you agree that a broad-based approach to financing it would be superior to the approach we have now?

Mr. VLADECK. Absolutely, yes, sir.

Mr. MCCRERY. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Dr. Vladeck, it just astounds me that you would move a specific benefit for a particular person to the general fund, the home health care transfer, and you would not take something that has a broad-based societal benefit like graduate medical education and look for it from that broader general fund. It is the kind of concern the gentleman from Louisiana and I share in terms of the real logic of working our way out of a 1965 A–B box. What you are doing only gets us deeper. We are looking for ways to try to figure out a rational use of general fund money for a broader societal benefit.

Mr. VLADECK. Mr. Chairman, if I could make an observation, I think that that is a commentary on some of the ways in which all of us act as a result of the Budget Enforcement Act and the way we define some of these things. I think that in some aggregate sense, you are absolutely right that in fact what we are doing on home health in accordance with the budgetary rules under which we all operate, has no net effect on the Federal deficit, whereas the creation of a trust fund, however, as wise a policy as it might be under current budgetary rules, would have a very different kind of consequence. I share your frustration about some of the constraints that these rules impose on us.

Chairman THOMAS. All of us should struggle to deal with reality rather than the virtual reality of the budget rules.

It is my pleasure to yield now to the newest Member of the Subcommittee, the gentleman from California, Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman. I am looking forward to working with you on these issues.

I thank Mr. Vladeck for being here as well and look forward to continuing to work with you. I appreciate the work you have done in helping Los Angeles County cope with its health care problems.

Let me ask you about a couple of issues that relate mostly to public hospitals. Obviously, Los Angeles County, with its recent experience, is trying to come up with a different way of providing health care to its indigents and has been searching for ways to try to cut costs. And I know you are doing things on DSH—can you give me a better sense of how you are going to provide a formula that will better target DSH dollars toward those hospitals that are absolutely providing that care versus hospitals that at some point do provide some of that care, but the bulk of it is going to those public hospitals and those charitable hospitals that are in low-income areas?

Mr. VLADECK. This is one of the areas of the President's bill, sir, where I think some of the concerns about not yet having all the details available are relevant because—although I cannot answer your question very well—on this issue in the Medicare Program, frankly, we have proposed something of a punt. We are very much concerned that merely by the effect of the changes in welfare reform, our ability to measure disproportionate share services or uncompensated care services in the way it has been defined in Medicare over the last decade or so is substantially weakened. We need a much better way of measuring disproportionate share and targeting it for both Medicare and Medicaid, and frankly, we do not have the answer to that at the moment.

What we do propose in the legislation, therefore, is that essentially, we freeze the level of DSH funding for the Medicare share for all hospitals for 2 years and require the Secretary to make an additional recommendation back to the Congress on how to fix and improve the formula.

I have proposed to my colleagues that we write the legislation so that the onus for a new formula was not on us, but that we assign that responsibility to the Prospective Payment Commission or someone else, because it is very difficult to do. However, we were not able to totally get ourselves off the hook.

I guess that is a long answer to the question to say we know that we have a problem—we have had a problem for a long time in the best way to measure and target DSH dollars. This problem is significantly exacerbated by changes in the income maintenance systems for low-income people which were the heart of the measurement process for DSH in the past.

We need to come up with a new way to measure and target. We need to mandate on ourselves in the statute the need to come up with a new way, but we do not have it yet.

Mr. BECERRA. That AAPCC carve-out that you are making for DSH and graduate medical education and so forth, those hospitals, do you think you are headed in the right direction trying to pull out the dollars you need for that? With this welfare bill that recently was signed with the growing tendency toward managed care, how do public hospitals that are also teaching hospitals survive?

Mr. VLADECK. I think that is a very real issue. What we have proposed—I know I am getting near jurisdictional turf here—but what we have proposed on the Medicaid side, for example, is actu-

ally a reallocation of some of what have been Medicaid DSH dollars to safety net institutions. Because of concern with the growth of capitation in both Medicare and Medicaid, some of the subsidies which we have built in in the past for these institutions are endangered, as HMOs steer their patients to other kinds of providers.

With regard to Medicare, we believe that if we pull the money out of the capitation payments, and if we can obtain a better measure to target these dollars, we can do what we can to address this problem. The Medicaid issue also requires more targeting.

The other problem is that many hospitals like hospitals located in Los Angeles County, which are major academic centers and major providers of services to low-income people, have a relatively small share of their business on the Medicare side, so that the ability to help these hospitals directly through the Medicare Program is somehwat constrained.

When I was a trustee of the public hospital system in New York City, we kept talking about Medicare rate enhancements, because we did not have many Medicare patients. I think that that is why a trust fund sort of direction, in which we pool sources from all payers and reallocate funds based on the nature of the program or the nature of the services being provided is where we need to go as soon as we can figure out how to do it.

Mr. BECERRA. But doesn't the trust fund still leave, in effect, the possibility of having an inequitable formula that ultimately drives dollars in the wrong direction and constantly causes you to have to turn to a trust fund, which will probably have to grow and grow and grow?

Mr. VLADECK. Well, the fundamental problem is a twofold problem in that we have a large and growing number of people in the United States without health coverage at all, and as we try to reduce the expenditures on both public and private health insurers for people who do have coverage, the ability to subsidize the services for the uninsured is getting increasingly strained. I think that that is why, again, over time, in the longer term, we have got to get to the root cause of this problem, which is the growing number of people without health insurance, and address that issue.

Mr. BECERRA. If I could add just one last question, there are all sorts of ideas floating around these days on how you can try to get—I guess the estimate is 10 million children who do not have health insurance—some folks are talking about some form of tax credit for kids that goes to a family so they can afford to get their kids into some kind of program.

I know the Secretary mentioned that her program would bring in an additional 5 million children under some form of health protection. I was wondering if you could tell me how you plan to do some of that outreach that apparently is going to bring in 1.3 million children just through outreach. I am interested to know what is so new and novel that we have not done or known about that is going to get us 1.3 million more kids into the system.

Mr. VLADECK. We are just starting to meet with the Governors and some of the public health agencies and so forth to work on that, but my own sense of it is that the opportunities we are missing—we have a pretty hard number that there are about 3 million children in the United States at the moment who are legally eligi-

ble or entitled to Medicaid, but not enrolled, and that is the target population for trying to enroll 1 million to 1.3 million children.

I think that if you want to enroll children, then you go to the schools, and for children below the age of 5, then you go to the preschool arrangements. We are expanding Head Start, and we are expanding subsidies for child care, so that increasingly we will know where they are in that sense.

In the past, individuals operating these services may or may not in a pro forma way have worried about the coverage of the children they were serving. However, I think that this is going to be where a lot of this action occurs in the short term. Just as we have used the schools as a vehicle for seeing that at least by age 5 or 6, children are immunized, it is the vehicle through which we have got to see that children who are potentially eligible for health insurance get it, and I think that that will be the primary focus, at least at the outset.

Mr. BECERRA. And if I could just encourage you, as you try to get the local governments to focus on how they can try to help you capture these kids, to think about where you are going, these areas that you are going, and look at the demographics, and if you ask folks to be a little bit more linguistically and culturally sensitive to the areas where they are traveling, they will probably have much more success in capturing some of these kids.

Mr. VLADECK. No. We cannot do this from Washington or Baltimore. This has to be done on the street. We understand that.

Mr. BECERRA. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Certainly.

Bruce, yesterday, I asked the Secretary when she was in front of the Full Committee about the operational policy letter that is going to be issued or which has been issued, clarifying for Medicare managed care plans the requirement that outpatient mastectomies or lymph node dissections not have a fixed maximum length of stay in the hospital for inpatients. I believe the letter says that these kinds of decisions "are better made by the patient and her physician after assessment of the patient's individual circumstances." And I know the American Cancer Society has said that under certain conditions, an outpatient procedure is entirely appropriate for mastectomies, but always referring back to the patient and the physician decisionmaking structure.

I tried to get the Secretary to explain to me—and it is very tight in the 5 minutes we have in that kind of Full Committee structure—what the purpose of the issuance of that operational policy letter was in contrast to the President's stated position in his State of the Union Address of supporting the DeLauro legislation and other legislation of that type, which would require a specified hospital stay. And she did not really have enough time to explain it. She was talking about the fact that under Medicare, we have the ability to do certain things versus other areas.

What is it that you did—for example, my understanding is that this letter was addressed just to the managed care HMOs. Does the letter go to fee-for-service as well, or not?

Mr. VLADECK. No, Mr. Chairman. There needs to be another series of letters addressing this issue on the fee-for-service side, and

the process of generating these letters is underway. We are probably 1 week or so behind because that is a more cumbersome process.

Chairman THOMAS. Here is my problem, and I am trying to be as objective as possible in looking at your responses, because frankly, I think HCFA and Medicare have served a useful purpose in the last year or so about issuing directives that were reasonable and appropriate—and notwithstanding the gentleman from Maryland applauding you for your emergency care definition of a "prudent layperson," while your definition of a "prudent layperson" is significantly different than his definition—I do not know whether it is the "prudent" or the "layperson" that is the significant difference—I do think your proposal helps bridge the gap between us.

When organizations align themselves with your declarations, we do have to see if in fact it filters down to actual behavior change, performance change and standards. But you have offered, I think, a way out of this business or the penchant or the recent desire to lock into legislation practices that really should be left to, in my opinion, and I think a lot of peoples', physicians and patients.

As I looked at the directive that just went out to managed care plans on mastectomies, we looked around for some statistics in New York State because they do a good job—I am sure you had some part in making sure that that data was collected. For example, in 1995, there was a total of 7,016 mastectomies. Of that 7,016, 6,892 were inpatient, or 98 percent. Of the 2 percent that were not, the 124 that were outpatient, the mastectomies performed under a Medicare HMO as an outpatient were 2.

I am just wondering why you were—and if this is replicated across the country, I am sure the numbers might adjust here or there—but 2 out of 7,000 in the State of New York versus the fee-for-service number would seem to me that when you deal with issuing these kinds of directives, you might focus on where "the problem is," notwithstanding the bureaucratic difficulty of generating it because, quite frankly, when you put this out, there was enormous press generated, and to be as objective as I can be, it sure made it look like the HMOs were in the rip-off business, and that they did not have quality medical standards and that you folks had to go after them. And here I am looking at 2 out of 7,000 mastectomies that you are going to clean up with the directive that you sent out in the State of New York, and we are trying to compile data countrywide.

I liked your earlier level of performance and objectivity. I do not know why and how this was driven to be sent out when it was. But if you were going to have a fee-for-service directive going out, it might have been wise to hold both of them and release them at the same time.

Mr. VLADECK. I think that point is well taken, Mr. Chairman, and I would acknowledge that we should have had both letters ready to go simultaneously; you are absolutely correct.

Chairman THOMAS. Now, just let me say also—I know you are going to do it as soon as you can—but we have a hearing scheduled for February 25 with ProPAC and a number of actuaries, looking at the whole question of the AAPCC and how we might revise it.

If we could get those county-by-county numbers before then, it would be a lot more fruitful.

Mr. VLADECK. You will have them, you will have them. Again, you will have them no later than the Friday before, but I hope you will have them earlier than that. We would not want Dr. Kahn and others to work over the weekend on that, so we will try to get it midweek.

Chairman THOMAS. Thank you. At the very least, the 48 hours we talked about.

Mr. VLADECK. At the very least.

Chairman THOMAS. Thank you.

The gentlewoman from Connecticut.

Ms. JOHNSON. Thank you, Mr. Chairman.

As the hospitals have been under more pressure, Mr. Vladeck, most of them have included their staffs to a far greater degree in meeting the challenge of reducing costs, and as the staff has focused more on how the hospital operates, they have become far more critical of how Medicare operates. I want to throw out a couple of little things that I would ask you to get back to me on.

For example, the requirements under Medicare for Neupogen in the treatment of cancer. According to the physicians in one of my hospitals, instead of it costing $900 a course, it could be down to $100, if we would allow them to just write a prescription and deal with it in a simpler fashion. I will be getting back to you on that.

Those little things are very distressing, when people can see that we have pushed the costs up 90 percent.

In mammograms, if a senior wants to have an annual mammogram, although Medicare only provides it every other year, and is paying for it herself, Medicare requires she sign a waiver of liability under part A and a waiver of liability under part B. Now, first of all, this is more paperwork for the hospital. It takes time to explain this all to the senior, and it scares the senior, when in fact, Medicare has absolutely nothing to do with this situation, we do not cover annual mammograms, and the mammogram the person is buying, they are paying for.

I would like HCFA to review that policy and I would hope repeal it, but certainly I would like to hear from you on that requirement because for small hospitals, that is significant.

[The following was subsequently received:]

The President's fiscal 1998 Medicare budget proposals include provisions to expand Medicare's coverage of mammography screening for beneficiaries age 65 and over. This expanded coverage would be effective for services provided on or after January 1, 1998. Current law already provides coverage of annual screening mammograms for women ages 50–64, and those at high risk, ages 40–49. Screening mammograms for women age 65 and over are now covered only biennially, even though breast cancer mortality increases with age. This President's proposal would remove this anomaly in current law and make coverage consistent with the frequency recommendations of most major breast cancer authorities.

Ms. JOHNSON. On bone density testing, very important to preventing osteoporosis, the HCFA policy goes back to 1984. It is so outdated that it lists technology that is no longer available. As a result of the outdatedness of our policy in regard to bone density testing, coverage policy across the Nation is very inconsistent. I would like to have HCFA get back to me on when you intend to update that policy; it should not be hard. The knowledge in this

area now is very advanced. There are whole groups of seniors who do not need bone density testing and so on and so forth, but we need a modernized policy so there will be more consistent access across the Nation for seniors who need bone density testing, which is very important to their well being.

[The following was subsequently received:]

HCFA is committed to reevaluating coverage policy for bone mineral density (BMD) studies. Currently, Medicare's national coverage policy pertaining to coverage of BMD studies does not include any discussion of dual-energy x-ray absorptiometry (DEXA) BMD scans for use in monitoring the treatment of osteoporosis. Since there is not a national coverage policy on DEXA scans, the local Medicare contractors make coverage decisions on claims for these tests, which may result in some variation in coverage in different parts of the country.

As part of its effort to evaluate coverage policy of BMD studies, HCFA requested five technology assessments from the Center for Health Care Technology (CHCT) in the Agency for Health Care Policy and Research (AHCPR). Four of these assessments address bone mineral densitometry for patients with secondary osteoporosis, specifically patients with asymptomatic hyperparathyroidism, patients with chronic end-stage renal disease, patients on long-term steroid treatment, and patients with vertebral abnormalities. (Patients with secondary osteoporosis comprise less than 5% of the population with osteoporosis.) HCFA also requested a technology assessment for patients with primary osteoporosis (osteoporosis brought on by age and postmenopausal changes).

Three of the four assessments of BMD studies for secondary osteoporosis have been completed by CHCT. The assessment of BMD studies for primary osteoporosis, which is the assessment of greatest concern because it pertains to 95 percent of the Medicare population with osteoporosis, has not been completed.

When the medical assessments have all been completed by AHCPR, we will reevaluate Medicare's coverage policy for BMD studies, including DEXA, and take appropriate action based on that evidence.

Ms. JOHNSON. Those are three little examples of things that I would like to get to, and then I do want you to comment on the policy you have just announced, or perhaps are about to announce, in regard to mastectomies. Again, as my Chairman said, you have announced a number of very thoughtful policies that are relevant to the problems we face, but you do point out in this policy that conclusive medical research and evidence does not exist sufficient to conclude that women derive any benefit, pro or con, from a definitive number of hours in the hospital following a mastectomy or a lumpectomy. In the research that does exist, very little is applicable to Medicare beneficiaries, who are generally 65 years or older, and therefore decisions of length of stay following a mastectomy or a lumpectomy should be left to the discretion of a doctor and patient on a case-by-case basis.

It is a curious contrast between the actions of the Department and the endorsement by the First Lady of a bill that sets specific hours. I think it is a problem from the national level to set specific hours. I think your policy directs itself at guaranteeing Medicare beneficiaries appropriate care, and I commend you for it, but I would appreciate your comment on that.

Mr. VLADECK. Well, thank you. I believe as a general matter that enrollees in Medicare managed care plans currently have much better consumer protections than do privately insured individuals as a general rule. I believe this example illustrates the extent to which we can ensure that Medicare managed care plans both have grievance and appeals procedures and have other sets of rules about how decisions are made which are not uniformly required on managed care plans in the private sector elsewhere in the country.

Ms. JOHNSON. Thank you. I see the red light is on, and there is just one little thing I want to mention.

I appreciate that because we are looking at the issue of appeals procedures and managed care plans, and I think those kinds of protections are probably the right answer. I would also like to say that I look forward to working with you on the issue of respite care policy. I know many seniors who are carrying the burden of full-time care of a spouse who has Parkinson's or a stroke or cancer, and I think we do not want to create an inequitable benefit, and we also want to be sure that as we develop postacute care bundling, we do it in such a way that the small agencies at the local level will have just as good an opportunity to serve, and we do not preference regional providers.

And as we move forward, I do hope to have the opportunity to explore much more in depth your approach to establishing preferred-provider service organizations. We worked on that at great length in our bill because it will provide a nonprofit, noninsurance company competitor to insurance company-provided managed care plans—not that they are not good, but you want competition from plans where the power of medical decision is clearly with the provider, and unless you do antitrust relief, unless you adopt new asset standards for PSOs, you will not get them developing in the market, and they are very much afraid that by the time they get in, the big plans will have already taken all the patients.

It is imperative, again, that we not let another year pass without making those changes, but I would hope that your proposal when it comes to us in detail will show some sensitivity to the antitrust problems that impede the development of provider services organizations where doctors and hospitals do have the power both economically and medically.

Thank you.

Chairman THOMAS. The gentleman from Nevada.

Mr. ENSIGN. Thank you, Mr. Chairman.

I want to get into a little bit about the whole idea of skilled nursing facilities and the 3-day hospital stay. Dick Durbin and I last year introduced some legislation dealing with that. I would like you to discuss what the administration feels about certain DRGs being classified and waiving that 3-day hospital stay for savings for Medicare.

Mr. VLADECK. Thank you. I guess there are three pieces to the answer. As I am sure you know, OBRA 1990 says the Secretary has the authority to waive the 3-day hospital stay, if she can certify that doing so would be budget-neutral for the program.

The last time we looked at that systematically was in 1994 and 1995, and our actuaries would not provide an opinion to that effect. We had not, prior to the suggestion that emerged last year, looked at whether that legal provision would permit us to waive it on a DRG or a diagnosis-specific basis. But with the development of a prospective payment system for Medicare SNF services, I think that changes the ball game. We would be happy to consider this issue with you as we go through the process this year because to the extent that the prospective payment system is going to work appropriately for some of those diagnoses, we may well be able now

to talk about the 3-day stay no longer being necessary. However, I think we would have to tailor it a little to reflect the characteristics of the new payment system, and I will confess we have not figured that out yet, but it is something we ought to address.

Mr. ENSIGN. Thank you.

We have gotten a little contentious occasionally today, but I also want to compliment the administration on some of its proposals on the preventive side. I think one of the things about Medicare is that it does provide a model for a lot of the other private health insurance companies to follow, and the more we can turn what has been termed our "sick care system" into a health care system, I think the better quality of life people will have, and I think that overall in the long run, it is going to save a lot of money. When we start getting farther into this and worrying about trying to reimburse people for keeping people healthy instead of only reimbursing them when people get sick, if we just change our paradigm and our mindset to think in those terms—and the mammography portion, although it is still somewhat of a "sick care," it is trying to catch something earlier, so at least you are trying to keep people as healthy as possible—but the diabetes and the colorectal and the rest, I applaud your efforts and what the administration has brought forward on those areas.

Thank you, Mr. Chairman.

Mr. VLADECK. Thank you very much.

Chairman THOMAS. Thank you.

Let me ask a couple of questions and probably ask you for some materials, and this will be back on the legislative language, Dr. Vladeck.

We are going to be with ProPAC next month looking at the DSH adjustment payment structure. I know you folks really did not do anything on that—you are simply pulling it out. If we can sit down and work around the ProPAC suggestions, it just seems to me that as we move through reconciliation, this is something that if we are all able to close on, we ought to close on, because we are going to continue to redefine what "low income" is, and there are going to be some outreach efforts.

I think it would be fruitful if we did that.

Mr. VLADECK. Mr. Chairman, I would love it. Let me just say—and I do not mean to be off-putting at all, but as you know, I am a ProPAC alumnus myself; it has been at least a decade that I have been involved on and off in looking at this issue—it is really hard. If we can do something over the next 6 months, if you can do something that makes sense, or if ProPAC can, we would be delighted. I just do not want to give any false impressions of feasibility. Anything anybody can do to contribute, we would eagerly support.

Chairman THOMAS. But we can certainly make a good faith effort in this area because of the changes that we are making in terms of shifting pots of money; we should at least make the effort.

Mr. VLADECK. Absolutely.

Chairman THOMAS. The other thing I am concerned about, and I do not know exactly what you are doing, although it is fairly easy to understand in a general sense, is that you are talking about as you make these other changes in HMOs, examining the benefits

that they use as inducements or additions, and you are going to try to standardize them. One of the concerns I have in that process is that as you are cutting down whatever margin of ability the HMO has to put a package together that makes it more attractive, which you are doing by reducing and squeezing out those areas. At the same time, if you are going to move forward with the standardization—my hunch is that you may wind up, because you are standardizing and prioritizing them to a certain extent as well, that is, if you are going to do them, you have got to do this one first, this 1 second, and so forth, or at least this one first—I am concerned that while you are talking about creating an increased choice for the consumer, and you are concerned about the ability to compare, you may wind up killing the goose that laid the golden egg because you do not have anything to compare it, because they are not offering it, or they cannot meet your standard which is now an additional criterion, since they have to actually meet what it is you offer on the fee-for-service side.

My concern has always been that if you really want to increase changes, let us talk about good oversight of a structure which moves toward an actuarial equivalent to a 1965 concept of what you need to make sure you get benefit for your money, but you do not standardize everything, which really loses that whole concept of change in choice that you are beginning to focus on.

Mr. VLADECK. Your points are very much on target, Mr. Chairman. We recently reviewed a little informal work which we did and would be happy to share with you regarding the dynamics of change in some of the Medicare markets that have occurred over the last 5 years. You will find a couple of things that have occurred—and I will not identify particular markets here; we would be happy to talk to you about them—that have influenced our thinking quite a bit.

The first is that we have had several markets in which the existing plans were offering some limited supplemental benefits at some modest premiums, and aggressive new entrants have come in, and after 2 or 3 years, lo and behold, everybody in town is offering more generous benefit packages at a zero premium, which is the basic. If your barriers to entry are not too high, you will get new competitors who will drive the market, and that is why you need more competition.

The other thing we find, which is worthy of some more explanation, is that plans in the markets which we are watching do not tend to seek to differentiate themselves in terms of a benefit package. It does not seem to be, as part of a marketing or long-term strategy, one of the things they do; in fact, there does tend to be enormous convergence around the supplemental benefit package, and they seek to differentiate themselves in other ways.

Now, that does not mean that over time, we should not allow for opportunities for plans to make their marks or to build their market share or whatever by being more creative on the benefits side. It is just that, again, our observations of what is happening in these actual markets in recent years suggests that that is not one of the three or four top number of things by which a plan seeks to distinguish itself.

Chairman THOMAS. I would only say that obviously, all of them will try to reduce or eliminate an out of pocket. That is a very attractive immediate. We have seen them then move to paid prescription, which obviously is not on the regular program, and then it begins to diminish in what you do. And obviously what you do is try to line up with your competitors so that you are not significantly different.

I guess to me, the value of that, although you may not see it as a value, is that it is the marketplace that is determining what it is that people want, and to the degree you move toward standardization, it becomes more a bureaucratic structuring that determines what is available to the beneficiary than it does the market forces. I am just concerned that we almost always go to the direction of standardization for comparison purposes which we view as a good which may not necessarily reflect itself in the market.

Mr. VLADECK. No. I understand the balancing act there, and we need to work with you because there are two conflicting valid goals there, and I agree with you.

Chairman THOMAS. Yes.

The gentleman from California wanted to get back in.

Mr. BECERRA. Yes. Thank you, Mr. Chairman.

Mr. Vladeck, let me ask you to comment on some discussion that has taken place over the course of all this health reform discussion about moving the Medicare Program into a defined contribution plan scenario where you are really giving that beneficiary a lump sum or a certain bag of goodies, and once they use up the goodies, they have to turn to their own resources to try to come up with their payment of health care costs.

You do not go in that direction, from what I can tell, with the President's proposal, and if you could tell me what your thoughts are and what the administration's position is on that, and then if I could ask a couple of questions after that.

Mr. VLADECK. Thank you. Yes, I think we can be very direct and try to be very specific. We believe the basic social contract embodied in the Medicare statute implies a defined set of benefits. It is for the availability of a defined set of benefits for their parents and eventually for themselves that we have asked people to contribute part of their wages over the last 30 years.

It is true that from the point of view of budgetary neatness or predictability, the problem with the defined benefit program, particularly in health care, is that it introduces something of a wild card into your budgetary calculations because you can never control the government's outlays as precisely as you could if you said, We are going to spend x dollars and no more per beneficiary.

On the other hand, we believe that a defined contribution plan would in effect transfer the risk of excess rise in health care costs or excess epidemiological phenomena are driving up the health care costs from anything else would transfer that risk from the government and the public at large to beneficiaries, which is exactly the wrong thing to do. It is a way of picking on the weak.

We are very strongly opposed not only to anything that would explicitly turn Medicare into a defined contribution plan, but anything that would implicitly or indirectly move it in that direction.

Mr. BECERRA. What if we placed on top of that scenario a balanced budget amendment in the Constitution that required us every year to balance the budget without regard to the costs of medical care?

Mr. VLADECK. Well, my concern would be more indirect. I think if we did that under current law, we would be putting many of the providers of service to Medicare at risk in a way that would be very destructive not only to the program but to the health care system over time. But again, even there, I would rather live under a scenario in which we said if we bump up against some kind of external ceiling, we are going to take across-the-board hits from providers—that would be a real problem, but it would be in my view not as bad a problem as saying if we bump up against a ceiling, we are going to increase the out-of-pocket liabilities of beneficiaries, which a defined contribution plan would do.

Mr. BECERRA. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Certainly.

The gentleman from Louisiana is fond of saying that people will consume all the health care other people are willing to pay for, and whether we like it or not, that will be an ongoing societal debate—what is the appropriate amount that other people are willing to pay for other people's health care.

If we have a structure which defines it as those people who receive the care rather exclusively rather than those people who pay for it, you will not only be exacerbating the problem of controlling the largest and the fastest growing area of the Federal budget, but you will be exaggerating the problem we now have between generations in the most significant and largest transfer of wealth in the history of the world between generations.

My question: The Federal Employees Health Benefit Program, which is held up as a model constantly—in fact, a Senator whose name I will not mention used it as an example of where he would like to go with his reforms in Medicare—is the Federal Employees Health Benefit Program a defined benefit or a defined contribution program?

Mr. VLADECK. It is really neither, sir, but it is closer to a defined benefit program than to a defined contribution program.

Chairman THOMAS. And so I get a number of benefits regardless of the price, or do I get a dollar amount that is paid by the government?

Mr. VLADECK. Neither. Every year, the amount of the dollar contribution paid by the government is determined by a very complicated formula that is essentially benefit and price driven, not by any external budgetary formula. It is an effort to assess—it is very analogous to what we do in Medicare, although more complicated, in the sense that it basically prices a benefit package in any given year and then establishes an equivalent contribution level for capitated or other plans tied to the price of the fee-for-service benefit package.

Chairman THOMAS. Notwithstanding its complexity, is it better than what you do in Medicare?

Mr. VLADECK. No. I think it is inferior in a couple of ways, but it has one enormous advantage over Medicare——

Chairman THOMAS. Because it is more dollar driven than benefit driven, and Medicare is more benefit driven?

Mr. VLADECK. No. It is inferior to what we do in Medicare because it pays a lower proportion of the cost of the basic benefit plan.

Chairman THOMAS. Well, notwithstanding what portion it pays, the way in which it determines what is the appropriate contribution by others to support an individual's health care needs.

Mr. VLADECK. I think if you really tried to take apart the formula by which that is done, and if it were applied to something as visible to the Medicare budget, I think it would be hard to defend over a period of time, just as a mechanical way of setting the contribution level.

Chairman THOMAS. Any additional questions?

[No response.]

Chairman THOMAS. Thank you very much.

Mr. VLADECK. I appreciate it, Mr. Chairman.

Chairman THOMAS. We look forward to all that data so we can move forward.

Mr. VLADECK. You will have it.

Chairman THOMAS. Thank you.

It is my pleasure now to announce the second panel, which consists of folks we know well and are pleased to have back.

Dr. Reischauer, who is now a senior fellow with the Brookings Institution, was Director of the Congressional Budget Office for half a decade, recently leaving to assume the senior fellow position.

Dr. Bob Helms is director of health policy studies at the American Enterprise Institute and involved himself in the structure of HHS for a number of years.

And Dr. Karen Davis, who has been with us both formally and informally over the years to assist us in understanding different ways of looking at the program, is currently president of the Commonwealth Fund.

Let us just start with the way you are lined up. Dr. Reischauer, we will begin with you and move across the panel.

Welcome, and you can inform us in any way you see fit. Thank you for your written testimony, and it will be made a part of the record.

STATEMENT OF ROBERT D. REISCHAUER, SENIOR FELLOW, BROOKINGS INSTITUTION

Mr. REISCHAUER. Thank you, Mr. Chairman. It is a pleasure to be here before you again.

My prepared statement addresses three issues—structural reform in Medicare, the role that Medicare should play in the effort to balance the budget, and the President's Medicare proposals. Let me say a few words about each of these.

First, with respect to structural reform, I would like to make four points. First, structural reform is clearly unavoidable. Second, the extent or ultimate shape of that structural reform for Medicare is at this point unknowable; it will depend very much on how the employer-sponsored marketplace evolves over the course of the next 10 or 15 years, and we really do not know where that will lead.

Third, just because we do not know the ultimate shape of the structural reforms that are needed in Medicare, we should not delay initiating change. The longer we wait to begin structural change, the more rapid those changes will have to be, the more wrenching the adjustments will be, and the more constrained the policy options available to the Congress and the President will be.

It is in my judgment that this year is an appropriate time to begin restructuring for several reasons. First, the 65 and over population is going to grow very slowly over the next decade—about nine-tenths of a percentage point a year, slower than it has grown in the previous 10 years, slower than it will grow starting 10 years from now. What that means is that any new structures that are put in place will not have to cope with a demographic tsunami as they are trying to root themselves.

Second, there is clearly an excess of providers available now. What this means is that if structural reform slips or makes a few mistakes, there is a very low risk that that will affect the quality of care or the access to care that beneficiaries face.

Moving to the role that Medicare should play in the effort to balance the budget by 2002, I will make three points. The first of these is that it is far more important that the 105th Congress start the process of structural reform than that it achieves 150 billion dollars' worth of savings for Medicare over the next 5 years rather than $50 billion.

Second, it is clear that Medicare should be expected to make a significant contribution to the deficit reduction effort because it is a big and very rapidly growing program.

And third, the way to achieve most of the savings that are needed over the next 5 years is through the mechanisms that have been used quite effectively in the past to reduce the growth of Medicare spending—not savings through structural reforms, but rather, savings through reduction in provider payments.

Let me move now to the President's budget proposals. The President has provided you with a good base upon which to build. Overall, I feel positive about his proposals, but I want to focus on three areas where I think there could be improvement.

The first of these has to do with the benefit expansions and policy changes that would reduce the costs on beneficiaries. In the former category is colorectal screening, in the latter category is the reduction in effective coinsurance on outpatient hospital services.

I think the policies the President has proposed in these areas make a lot of sense, but I think the President is sending the wrong message to the beneficiary population. He is sending a message that says beneficiaries can expect more for less in an era of fiscal austerity at a time when the HI Trust Fund is running a deficit and when we know Medicare faces big problems in the future.

I think a more responsible way of offering these benefits would be to ask beneficiaries to chip in and pay for them. This could be done by raising the part B premium by about $10 a month in the year 2002. At that point, premiums would be about 29 percent of costs. That would still be below where they were in 1995. I also would urge you to consider raising premiums back up to where they were in 1995, as well as imposing an income-related surcharge.

The second area that I would like to say a few words about is the President's proposal for changing the way HMO capitated payments are made. First, he would mix a national and a local AAPCC, which is a good first step, but the local component really should be based on a multicounty average rather than on a county average for costs.

Second, he would put a $350 floor under the capitated payments in rural areas, which is intended to increase choice in these areas. There is a possibility that this well-intentioned move might not produce the desired result. We could find that Medicare costs go up and choice is unchanged in these areas. This would happen if rural providers banded together, set up a PSO, and decided to see Medicare patients only through their new PSO. Then we would have a system that was largely unchanged except that the income received by providers would be higher.

The third change the President would make in this area is that he would reduce, after the year 2000, the capitated payments for HMOs from 95 to 90 percent of the AAPCC. My testimony suggests that it would be appropriate to begin this adjustment sooner, in fact to begin in 1998 by reducing the AAPCC payment by 2 percentage points a year. Two reasons are given for this. The first is that because the overpayment to HMOs will grow as HMO market share increases, it is important to get this started early because HMOs are growing very rapidly at this point. My testimony provides a rather extreme illustration of this, not intended to be realistic at all, but shows you the dynamic that occurs.

The second reason for acting sooner rather than later is a political one. HMOs devote part of the overpayment they receive to supplementary services to Medicare beneficiaries such as prescription drug coverage. When the Congress begins to ratchet down the capitated payments, plans are going to have a harder time providing members with these services without imposing additional costs. What will happen then is HMOs will tell their beneficiaries that policies being considered by Congress are going to lead to higher payments or reduced services, and you will face a political backlash and pressure, which will be hard to fend off.

Let me close by saying a few words about the President's proposed shift of some home health costs from part A to part B. From a conceptual standpoint, I think this is appropriate, but in my judgment, it is not a wise policy for two reasons.

The first of these is because it would put even more of Medicare in direct competition with discretionary spending and other mandatory spending in the effort to balance the budget. The political power of Medicare will almost ensure that these other areas of government service will be cut back more than otherwise would be the case if this shift did not take place.

The second reason is that the shift could put off the date at which the issue of structural reform would have to be addressed by Congress and the President. I know some of my colleagues here think that that is a good idea; I think it is a bad idea. Congress and the President are going to avoid this set of decisions as long as they can, and as I suggested before, we have a window of opportunity now which is actually quite good for beginning these structural reforms. Waiting until 2000 or 2002, when we have a new

President concerned about reelection and when many of the baby boomers are staring retirement in the face, is not going to be an easy time to begin to make these structural changes.

That ends my summary, and after my colleagues have spoken, I will be glad to answer questions.

[The prepared statement and attachments follow:]

Statement of Robert D. Reischauer,* Senior Fellow, Brookings Institution

Mr. Chairman and members of the Subcommittee, I appreciate this opportunity to discuss the future of the Medicare program with you. My statement addresses three issues:

- The need for structural reform of Medicare and the challenge such reform will represent.
- The contribution Medicare might make to the effort to balance the budget by 2002, and
- The Medicare proposals contained in the President's fiscal 1998 budget.

THE NEED FOR STRUCTURAL REFORM

From a fiscal, an institutional, or a political perspective, the Medicare program is not sustainable as it is currently structured. There is no immediate crisis; rather there are problems that will grow in severity over time. While there may be no need for precipitous action, the sooner the nation begins the inevitable process of restructuring Medicare, the less disruptive or wrenching the changes will be and the more options policymakers will be able to consider.

The fiscal problem is straightforward. Spending by Medicare, as it is currently structured, is projected to grow at a faster pace than the economy is expected to expand. The Administration expects that, over the next 5 years, spending on an unchanged Medicare program will grow at an annual rate of 8.9 percent while the economy will expand by 4.9 percent a year.[1] The Congressional Budget Office's (CBO) projections show Medicare growing by 8.8 percent annually and the economy expanding by 4.7 percent annually over the next 10 years. The Board of Trustees of the Medicare Trust Funds estimates that Medicare's disbursements will grow about 2.8 percentage points a year faster than the economy over the course of the next four decades. This somewhat more sanguine but still unsustainable projection rests on an optimistic assumption that there will be a sharp slowdown in the growth of spending per capita.[2] A program of Medicare's size can not grow significantly faster than the economy expands for a sustained period of time without requiring either drastic reductions in other government activities or significant tax increases.

The institutional problem arises because rapid changes are taking place in the non-Medicare insurance marketplace. Medicaid, employer-sponsored plans, and individual insurance are becoming, for the most part, capitated systems involving panels of providers and some management of care. Medicare, on the other hand, remains largely an unmanaged indemnity insurance program open to virtually any licensed provider of services. The institutional infrastructures needed to support these two very distinct types of insurance are different. The information requirements, regulatory needs, and management procedures of the two approaches will increasingly diverge, creating a certain amount of complexity, confusion, and inefficiency. The existence of two very different approaches may create incentives that affect, in a positive or negative way, the access to or quality of care available to Medicare participants. Incentives that increase cost pressures on Medicare could also develop.

If the Medicare and non-Medicare portions of the health insurance market continue to evolve along different paths, the strong political support Medicare has enjoyed since its inception could begin to erode. As originally conceived, Medicare was to provide the elderly, and later the disabled, with insurance coverage similar in

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*Senior Fellow, The Brookings Institution. The views expressed in this statement are those of the author and should not be attributed to the staff, officers or trustees of the Brookings Institution.

[1] Net of part B premiums.

[2] The *1996 Annual report of the Board of Trustees of the Federal Hospital Insurance Fund* (pages 8 and 71) states that HI program costs are based on an assumption that the growth rate of costs per unit of service will decline over the next 25 years until it reaches the rate of growth of average hourly earnings. The growth of per enrollee SMI costs is assumed to decline gradually after 2008, reaching the rate of growth of GDP per capita by 2020 where it is assumed to remain. Both of these assumptions represent a sharp slowdown from recent experience.

structure and scope to that enjoyed by members of the working population and their dependents. In recent years, increasing numbers of those covered by Medicaid, employer-sponsored plans, and individual insurance policies have found their choice of providers limited, their access to specialists controlled, their selection of prescription drugs confined to those available through a formulary, and their ability to obtain certain expensive procedures constrained. These restraints have not been greeted with enthusiasm. If Medicare costs continue to escalate necessitating tax increases or reductions in other programs, some may begin to wonder why the elderly and disabled enjoy more in the way of unrestrained access to providers and services than that which is available to the balance of the population. If this happens, Medicare's support among taxpayers could begin to wane.

While these developments imply that Medicare will not be able to avoid restructuring, it would probably be unwise for policymakers to attempt at this point to specify all of the details of a restructured Medicare program. As a general principle, the health insurance system that government provides for the elderly and disabled should be similar to, or at least compatible with, that available to the balance of the population. In recent years, the structures of Medicaid, individual insurance, and employer-sponsored plans have been changing at warp speed. This change could continue at a breakneck pace along the same path, come to an abrupt halt, or veer off in an entirely new direction. It would be unwise for policymakers to assume that they can forecast now where the private marketplace will settle when the convulsions cease. This suggests that restructuring Medicare should be viewed as an evolutionary process rather than a "big bang" event.

The fact that the ultimate destination is uncertain should not be taken as an excuse for delaying the journey. The general direction in which Medicare must move is fairly clear. Market incentives must be incorporated into Medicare. Participants will have to be given greater choice of plan types and incentives that encourage them to obtain their care from those providers who are both efficient and high quality. Institutions will have to be developed that can measure and monitor the quality of competing plans, disseminate information on the services offered by and performance of the different plans, enroll and disenroll participants, adjudicate disputes, and regulate the financial soundness of plans. It takes time to build such institutions, to get the kinks out of their systems, and to get participants, providers, and plans comfortable with the new structure. It would be best if this were done gradually and not when the new institutional infrastructure is required to bear the burden of fiscal restraint, which will be the situation a decade from now. In short, the time to begin the structural reforms that Medicare will have to undergo is now.

Current demographic and market conditions, which suggest that the risks and dislocation associated with restructuring are much lower now than they will be later, reinforce this point. For the next decade the nation will experience something of a lull before the demographic storm. The population that is 65 and over is projected to grow by 0.9 percent a year between 1997 and 2007 (or from 12.7 percent of the total population to 12.8 percent). This is less than the growth experienced during the previous decade. This suggests that any nascent institutional structures that are created will have a period to take root before being faced with the rapid expansion in number of participants that will take place after 2010. In addition, providers—particularly hospitals, physicians and other health professionals—are currently in excess supply. Furthermore, in contrast to previous periods, Medicare payment levels are not far below those of most private payers. Taken together, these conditions suggest that there is little likelihood that the introduction of structural reforms, even with a few slips and stumbles, will adversely affect access or compromise the quality of care received by Medicare participants. This was not the case a decade ago and may not be the case a decade hence.

Medicare's Contribution to the Balanced Budget Effort

With respect to Medicare, the 105th Congress should focus its efforts on initiating the structural reforms that will be needed to ensure that the program remains viable over the long-run. Unfortunately, most of the recent debate has centered on the contribution that Medicare might make to balancing the federal budget by 2002 rather than on structural reforms. Of course, restraining Medicare spending must be an important component of the deficit reduction effort because Medicare is such a large and rapidly growing program. The extent of these savings is limited only by the nation's commitment to providing the elderly and disabled with access to high quality, affordable health care and its concern about excessive disruption of the health care infrastructure.

Some notion of the amounts that Medicare might be expected to contribute to deficit reduction can be obtained by examining the various budget balancing plans that

have been proposed during the past two years. These plans called for Medicare savings that ranged from $100 billion to $270 billion. (Chart 1) These amounts constituted between one-fifth and one-third of the non-interest outlay reductions proposed by the various plans. (Chart 2A) Medicare spending would have been between 11 and 22 percent below baseline levels by 2002 under these proposals. (Chart 2B)

One can not make simple comparisons of the numbers in the charts because some involve seven year's worth of savings, some six years, and one five years. In addition, the baselines against which the savings are measured are different. In fact, between March 1995 and January 1997, CBO lowered its estimate of baseline Medicare spending during the 1996 to 2002 period by $104 billion. (Chart 1)

The current Medicare budget debate is likely to revolve around savings that range from $90 billion to $140 billion over the 1998 to 2002 period. Spending restraint in this range is achievable and should not be too disruptive of the provider community. Ultimately, the magnitude of the savings that Medicare might realize from restraining the growth of payments to providers and instituting certain efficiencies depends crucially on what happens in the private insurance marketplace. If employer-sponsored health plans continue to hold down the annual rate of growth of their per-capita costs to under 4 percent, larger Medicare savings might be possible. On the other hand, if the growth of private health care costs rebounds to the rates experienced during the last half of the 1980s, even $90 billion in savings would prove difficult to realize.

CHART 1

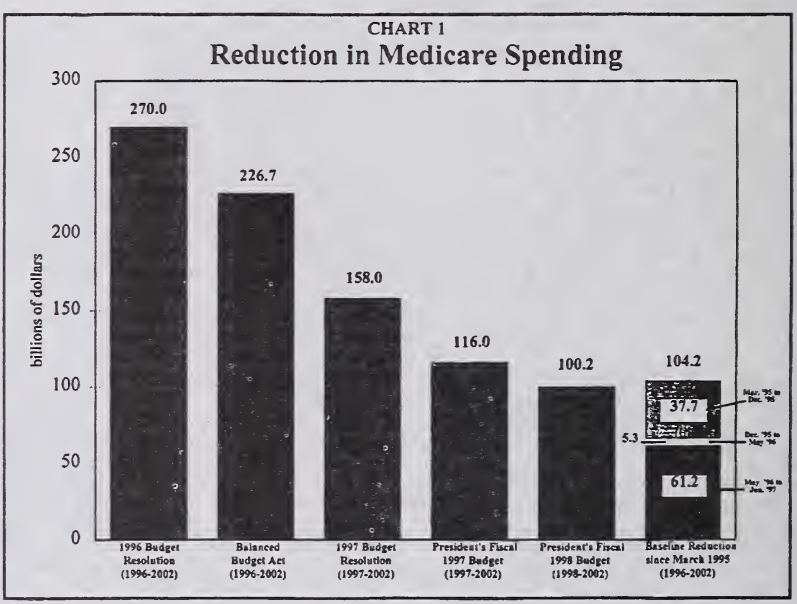


CHART 2A

Percent of Non-Interest Outlay Savings from Medicare

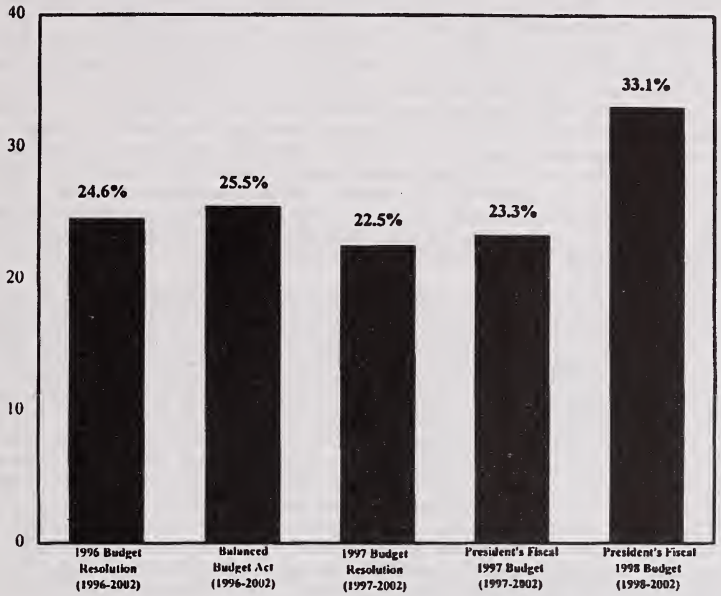
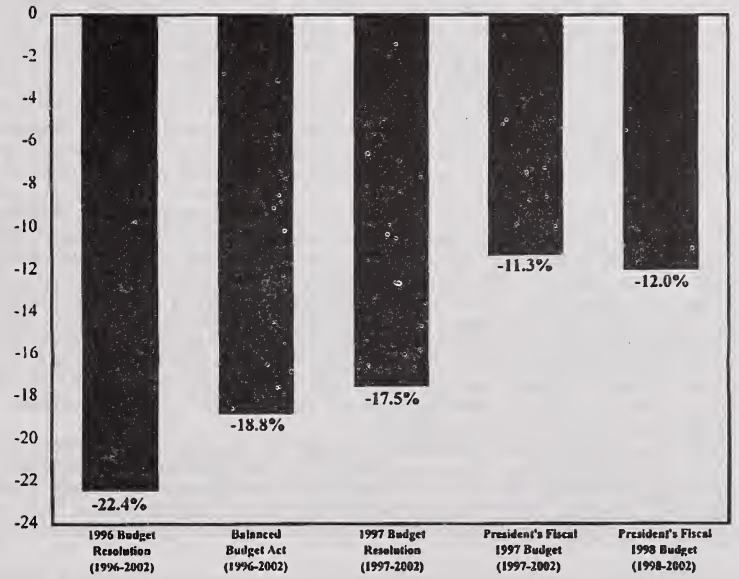


CHART 2B

Medicare Spending in 2002
Percent Reduction from Baseline



The Medicare proposals in the President's fiscal 1998 budget

The Medicare proposals in the President's 1998 budget constitute a good foundation upon which to build. The President calls for restraining the growth of payments to providers through many of the mechanisms that have been used effectively in the past. Most of the short-run savings are realized from these devices. While the savings proposed by the President are quite large relative to those that have been adopted in previous reconciliation acts, conditions are quite different now. It is likely that the restraints proposed in the President's budget could even be increased somewhat without risking any serious adverse consequences for participants.

The President's budget also proposes a number of new benefits and cost reducing measures for participants. The former include coverage of colorectal screening, a diabetes self-management benefit, annual mammograms, respite relief for families of Alzheimer's patients, and improved availability of preventive injections. The latter include eliminating cost-sharing for mammography services, reducing the cost-sharing for hospital outpatient services, lowering the premium surcharge for late enrollment in Part B, and changing the rules governing Medigap to make the premiums charged those leaving HMOs for the traditional fee-for-service system more affordable.

There are sound reasons for each of these benefit expansions and cost reduction measures. Nevertheless, the President's proposal sends an inappropriate message to Medicare participants. It tells them that they can expect to get more for less even in an era of fiscal austerity, even when the Hospital Insurance Trust Fund is spending more than it is taking in, and even when Medicare faces severe fiscal problems in the not-too-distant future. Under these circumstances, it would be appropriate to ask participants to bear the cost of the proposed Medicare expansions. These costs could be added to the Part B premium. This would raise premiums by about $10 a month in 2002. At that time, premiums would represent roughly 28.8 percent of costs, which is still below the 1995 level. Increasing premiums to their 1995 level and adopting an income-related surcharge on participants whose incomes are over twice the median would represent a responsible way of requiring Medicare participants to contribute to the efforts to balance and preserve the program for future retirees. For some this could represent a hardship, but many of the most needy would be shielded by Medicaid, which must pay the premiums of beneficiaries whose incomes are below 120 percent of the poverty threshold.

The President's budget proposal also contains a number of nascent structural reforms, some of which would affect the traditional fee-for-service component of Medicare and some of which would affect the capitated component. While the President's structural reforms are a positive step, they are too timid and tentative. On the fee-for-service side, the President proposes to replace the cost-based reimbursement of home health care, nursing home care, and outpatient hospital services with new prospective payment systems. The effort to move to prospective payment for post-acute care is commendable but fraught with technical difficulties which were discussed in a recent CBO study.[3] Unless movement to a PPS system is done with great care, costs could increase, individuals with heavy service needs could have difficulty obtaining care, and quality could deteriorate. Nevertheless, it is important to accept the fact that any measures which successfully curb the explosive growth in post-acute care spending will lead to some reduction and redistribution of services.

The President's budget also proposes that the Health Care Financing Administration (HCFA) be given greater authority to use negotiated prices and competitive bidding to set payments for non-physician Part B services. Such a procedure, which the President has proposed before, is long overdue. However, giving this authority to HCFA does not mean that it will be used. HCFA will be under intense political pressure to delay or make only very limited use of this authority. A bolder initiative would could promise more significant savings. One option would be to include minimum thresholds in the legislation. For example, Congress could require that at least 30 percent of the laboratory services paid for by Medicare in 2002 be purchased through competitive bids or negotiated prices unless HCFA provides evidence that such procedures would not be cost effective.

The structural changes the President proposes for the capitated portion of Medicare are more modest than those suggested for the fee-for-service program. The President would expand the choices available to participants to include Preferred Provider Organizations (PPOs) and Provider-Sponsored Organizations (PSOs) that meet certain standards as well as HMOs. While other plan types might be included,

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[3] Congressional Budget Office, *Medicare Spending on Post-Acute Care Services: A Preliminary Analysis,* January 1997.

the President is prudent to expand the range of choice very cautiously. Until we are confident that HCFA can risk-adjust the capitated payments paid to plans sufficiently to avoid serious adverse selection problems, the expansion of options must be done very deliberately.

The budget also calls for the dissemination of comparative information on the plans available to Medicare participants. From the information available, it is not clear whether a new entity would be established to collect, evaluate, and disseminate this information or whether the enrollment and disenrollment functions would be handled centrally by Medicare or would be decentralized to the plans. There are good reasons to establish a new entity to preform these responsibilities.

The budget also calls for significant changes in the way HMOs and the new types of capitated plans would be paid in the future. Rather than having payments strictly related to the local costs of fee-for-service Medicare, payments would be a blend of national and local fee-for-service costs. Local costs would still be calculated on a county basis, which does not make a great deal of sense when health market areas are much larger. The local cost component of the President's proposal should be based on multi-county averages. This would reduce some of the random year to year variability in payments and make payments more equitable. Why, for example, should a Medicare HMO operating within the Washington metropolitan area receive about $2,200 less a year for an enrollee living in Fairfax County, Virginia than for an enrollee residing in Prince Georges County, Maryland?

The President's plan would also place a floor beneath capitated payments in rural counties to encourage expansion of managed care into these areas. On the surface, this proposal seems both equitable and efficient. Under certain circumstances, however, it could result in less not more choice. If the capitated payment for the area were considerably above the average fee-for-service Medicare expenditure in the area, providers would have an incentive to band together and see Medicare patients only through their PSN, PPO, or HMO. In this way providers could maximize their Medicare incomes.

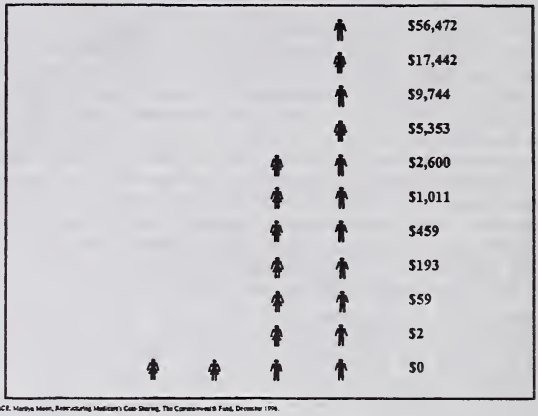
The President's proposal also calls for gradually reducing the average payment made to capitated plans from 95 percent of the AAPCC to 90 percent starting in 2000. This initiative responds to research evidence that suggests that if those selecting Medicare HMOs had remained in fee-for-service Medicare, they would have incurred costs somewhat below 95 percent of the average fee-for-service costs. If this is true and there is any positive correlation between the proclivity to enroll in an HMO and health status, the gap between the capitated payments received by HMOs and the costs of providing services to HMO enrollees is likely to grow as HMOs increase their market share.

Charts 3 and 4 provide an admittedly extreme and unrealistic illustration of this point. Chart 3 provides a picture of the distribution of per beneficiary Medicare costs in 1996. As is well known, costs are highly skewed with the most expensive one percent of the enrollees accounting for roughly 14 percent of the program's costs and over half of costs being incurred by the most expensive five percent of beneficiaries. Chart 4 depicts what would happen if Medicare participants enrolled in HMOs strictly according to their health status. The HMOs' costs to care for these individuals would rise as an increasing share of the population joined HMOs but the AAPCC would rise even faster because of the skewed nature of Medicare costs. When only the healthiest individual in the Medicare population, one who would incur no Medicare costs, participated in an HMO, the HMO would receive 95 percent of the AAPCC—or about $4,500 a year—and the individual might not use any of the HMO's services. If all but the most expensive one percent of the Medicare population joined HMOs, the capitated payment made to HMOs would be over $50,000 per participant, but the costs incurred per member by the HMOs might be only around $4,000.

CHART 3

Distribution of Medicare Expenditures per Beneficiary

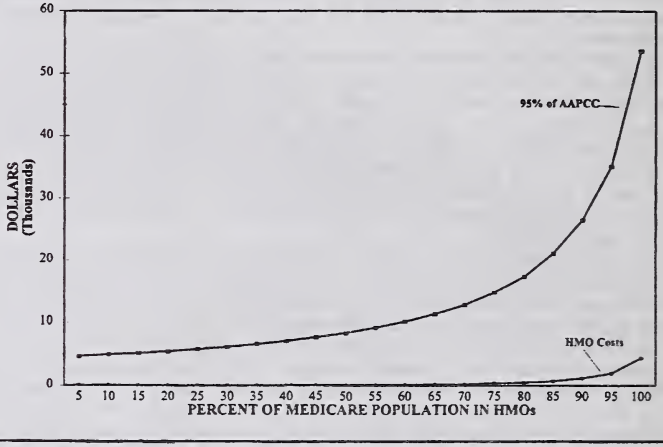
1996 ($4,753 mean)



SOURCE: Martha Mann, Restructuring Medicare's Cost-Sharing, The Commonwealth Fund, December 1996.

CHART 4

Extreme Illustration of HMO Revenues and Costs per Beneficiary as HMO Participation Increases



*Assumes that the beneficiaries with the lowest health expenditures join HMOs first.

Medicare HMO enrollment has been growing by leaps and bounds. In 1996 enrollment expanded by 36 percent and CBO projects Medicare HMO enrollment to grow by 30 percent in 1997 and 25 percent in 1998. Evidence suggests that Medicare HMO enrollees are younger and healthier than other Medicare participants. It is reasonable to expect that the dynamic illustrated in its most extreme form in Chart 4 is occurring and will grow in significance until the Medicare HMO population stabilizes and ages. If this is the case, policymakers should not wait until 2002 to begin ratcheting down the capitated payments made to HMOs. A gradual phasedown of possibly two percentage points a year should begin in 1998. As this reduction in capitated payments takes place, a substantial and continuous research effort should be mounted to measure the extent to which HMO participants are (or are not) less costly than their fee-for-service comparison groups. Congress should also instruct HCFA to devote more resources to developing risk adjustment mechanisms that could be used to modify capitated payments in an environment in which the payments made to capitated plans are decoupled from fee-for-service costs.

In addition to the analytical, there is a political reason for moving expeditiously to reform the capitated payment mechanism. In part because of the generous level

of capitated payments, many HMOs have been able to provide their Medicare members with additional services at little or no additional costs. Low cost sharing, vision services, prescription drug benefits, and routine check-ups are among the most common of these benefits. As HMO enrollment grows and more and more Medicare beneficiaries come to regard these benefits as an entitlement, it will be increasingly difficult to reduce HMO payments. Plans will tell their members that actions being considered by Congress threaten their prescription drug benefit or their vision care. The pressure will be intense. This suggests that moving soon and in small steps is preferable to waiting and taking larger leaps.

A final element of the President's proposal that merits some attention is his proposal to shift a significant portion of the costs of home health services from Part A, which is funded by the payroll tax, to Part B, three-quarters of which is supported by general revenues. Conceptually, the services the Administration would shift do not fit in the Part A hospital insurance program. However, the Administration's motive for this shift does not appear to be a quest for conceptual purity. Rather, it reflects political expediency—the need to make good on the promise to keep the wolves of insolvency from the trust fund's door for a decade without raising payroll taxes or imposing too much of a burden on Part A providers. The President's refusal to either increase Part B premiums to reflect the transferred costs or to subject transferred home health services to the deductible or coinsurance that most other Part B services face underscores the impetus behind the proposal. So too does the apparent failure to limit the home health services available to those beneficiaries who have only Part A coverage to the services that would be paid for from the Hospital Insurance Trust Fund.

But the real issue is not the motive behind this proposal but rather its consequences. The shift of home health expenditures to Part B will place an even larger portion of Medicare spending in direct competition with other programs for scarce budgetary resources. In a constrained environment, this inevitably will mean that discretionary and other mandatory programs will be cut more deeply in the effort to balance the budget. Equally important, the shift will serve to delay consideration of the types of fundamental structural reforms needed to preserve Medicare for the babyboom generation. Anachronistic as the Part A trust fund mechanism is, it serves the important function of forcing reluctant policymakers to restrain this popular program when Part A spending outpaces payroll tax receipts and the trust fund's solvency is threatened. Shifting a portion of the fastest growing component of Medicare into Part B, which can dip into the Treasury's bottomless well for funds, will only delay the unavoidable and make the needed adjustments all the more wrenching when they occur. The longer we wait to make these changes, the more constrained our options will be and the more prominent a role tax increases will have to play in the solution. If the political pressures are great now, they will be even more intense in a decade when the babyboom generation is facing the realities of retirement.

Chairman THOMAS. Thank you very much, Bob.
Dr. Helms.

STATEMENT OF ROBERT B. HELMS, DIRECTOR, HEALTH POLICY STUDIES, AMERICAN ENTERPRISE INSTITUTE

Mr. HELMS. Thank you, Mr. Chairman.

This little sign says: "Robert Helms, Assistant Secretary for Bureaucratic Fast Food." This was on my door at HHS some years ago. The origin of this little sign was an op-ed piece in the Washington Post that referred to one of the Reagan budget plans as "warmed-over policies and bureaucratic fast food."

I was reminded of this when I looked at the President's Medicare proposals. They consist of warmed-over proposals from last year and a bureaucratic shuffling of funds designed to extend the life of the so-called Part A Trust Fund. What the administration would describe as a prudent proposal to save Medicare and to give us time to debate fundamental reform, I would describe as another head-in-the-sand proposal that would distract us from the real

problems we already know are coming and should be addressed now.

We are now at a crossroads regarding the future of Medicare. The road that takes us across the President's bridge is a well-worn route to direct government controls of the type used in Canada and most European countries. In the long run, I do not think this is in the best interest of Medicare recipients, taxpayers, or, I might add, Members of Congress.

We have the opportunity to take a different road, a road to fundamental reform that uses the best of what we know about the delivery of quality health care, the economic behavior of consumers and providers, and the performance of competitive markets, to help save the Medicare Program in the next century. Such policies can do a lot to improve the efficiency of health care markets, but they may not be enough given the enormity of the problem.

As numerous other people have pointed out, the longer we delay facing the real problems in Medicare, the more difficult it will be to achieve what we all want, and that is a Medicare Program that is affordable and provides realistic choices to beneficiaries.

I see two fundamental problems with this proposal. The first is its emphasis on direct controls. I do not object so much to the amount of the reductions as I do the perverse incentives that I think these controls create. In particular, I think they threaten to create situations of excess demand where providers will have strong incentive to get around the controls. I think they will also have incentives to discriminate among potential recipients, in particular, picking those that have fewer medical problems.

Consumers will also have strong incentives to get around these controls, and, I might add, the controls create particular difficult enforcement problems for the agency.

There is little doubt that a government can reduce outlays if it is willing to devote increasing amounts of resources to enforcement. You can see examples of that in the current budget.

The alternative to controls is the kind of system I think we could get through competitive reforms. A competitive approach would create strong incentives for patients to choose health plans on the basis of quality and value, and strong incentives for providers to compete for patients on the basis of quality, service, convenience, and value.

The second major problem I have is the failure to deal with Medicare's long-term demographic problem. I have some quotes in my testimony from the trust fund trustees that I think are pretty alarming. One way to illustrate this is to convert their percent of payroll figures to actual dollar amounts. For example, the differences between Medicare expenditures and receipts under current law are $48 billion in 2000; $91 billion in 2005; and $154 billion in 2010. At this point we are not to the point yet where the baby boomers start to turn 65. These annual deficits then jump to $268 billion in 2015 and $456 billion in 2020.

By whatever standard you use, these are large numbers. They make the point that Robert Reischauer has already made, that it is time to get started on Medicare reform.

Let me also say a word about the transfer of home health care benefits. I think focusing on the home health care benefit in terms

of which fund it ought to be in misses the main point. The most important effect of this proposal is on the source of funding for Medicare. Since the payroll tax now funding part A is not reduced after this shift and the part B premium is not increased, the net effect of the transfer of home health is to transfer general funds from the overall budget to part A. This has the effect, as Robert Reischauer has already said, of further reducing the discretionary portion of the Federal budget. I think this shift creates longer run problems for the Congress and for the future of the program.

In conclusion, let me point out there are lots of market-based solutions we could follow that have been proposed. My own preference is a defined contribution plan. I think that that would be much more efficient than direct controls. I have seen Karen Davis' testimony and her emphasis on protecting the poor. I do not think such a defined contribution plan has to penalize the poor, but it will force us to be more explicit about what we are willing to pay for the poor.

Thank you.

[The prepared statement follows:]

Statement of Robert B. Helms, Director, Health Policy Studies, American Enterprise Institute

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We are now at a crossroad regarding the future of Medicare. The road that takes us across the president's bridge is the well-worn route to direct government controls of the type used in Canada and most European countries. In the long run, this is not in the best interests of Medicare recipients, taxpayers, or, I might add, Members of Congress.

We have the opportunity to take a different road, a road to fundamental reform that uses the best of what we know about the delivery of quality health care, the economic behavior of consumers and providers, and the performance of competitive markets, to help save the Medicare program in the next century. Such policies can do a lot to improve the efficiency of health care markets, but we should not promise too much. Given the enormity of Medicare's unfunded liability, even competitive reforms may not be enough. We will have to do even more to change people's expectations about what is realistic.

As numerous others have pointed out, the longer we delay facing up to the real issues in Medicare, the more difficult it will be to achieve what we all want—a Medicare program that is affordable and provides realistic choices to beneficiaries.

The critical choice for Medicare is between a system that relies on direct controls and one that relies on the incentives of providers and consumers. To illustrate why I think it is important that we start on the road to reforms based on market incentives, I would like to briefly describe two fundamental problems I see with the President's Medicare proposals.[1]

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[1] For a more complete treatment of this topic with numerous references to the economic and health policy literature, see my testimony to this committee on February 10, 1994.

Two Fundamental Problems

While the President's Medicare proposals present numerous detailed policy issues, I want to concentrate on what I think are two fundamental shortcomings in the basic policy approach being followed by the Administration.

1. *The emphasis on direct controls*: The President's budget proposes reductions from current law Medicare outlays by $132.4 billion over five years (FY 1998–2002) and additions of $32.3 billion, for a net saving of $100.2 billion.[2] The bulk of this reduction is from reducing payment rates for hospitals ($33 billion), physicians ($7 billion), home health agencies ($14 billion), and skilled nursing facilities ($7 billion), and reducing payment rates to Medicare managed care ($34 billion).

The objection to this approach is not the amount of the estimated reductions, but the perverse incentives they will create over the next several years. It is the nature of what budgeteers call "the wedge effect"—policies that force a lower rate of growth have continually larger effects as the years go by. The problem here is in knowing what wedge to measure when we are making comparisons between proposed policies and current market conditions. Both CBO and OMB measure savings against a baseline of what they estimate will happen under current law. But the actual effect on providers may be larger or smaller depending on what providers would have charged had they had more freedom to do so. If existing controls have had any effect on what providers actually receive, as seems logical for most medical markets,[3] then the effect of direct controls can be expected to increase over time.

There is a large literature about the effects of controls that push prices lower than would exist in a competitive market.[4] Controls affect providers on the supply side, consumers on the demand side, and the agency that is charged with enforcing the controls. Providers usually receive the most attention because the controls have a larger per capita effect in the income of providers and because they are usually better organized to complain about the controls. Effective controls give providers incentives to reduce the supply of the products or services being controlled. Even if it is against the law to reduce supply, there are many subtle ways to reduce the quality or convenience associated with the product or service.

One aspect of producer behavior in medical markets that should be of particular interest to policy makers is the incentive to discriminate among potential consumers (patients) on the basis of their medical condition. If both the provider and the patient are prevented from using higher prices to ration the available supply, then there will be strong incentives for the provider to pick only those patients that satisfy his or her own preferences, whatever they happen to be. The result is likely to be increasing problems for Medicare beneficiaries to gain access to the providers they would prefer to see. This lack of access could be expected to be greater for patients with more serious medical problems which expose the provider to increased risks.

In addition to these effects on providers and patients, controls also can be expected to cause increasing problems for the agency charged with enforcement. All markets have some degree of what can be called fraud and abuse. Direct controls which increase in their effect over time create a new definition of what may be considered illegal as both providers and patients have growing incentives to charge and pay illegal payments to circumvent the effects of the controls.

There is little doubt that a government can reduce outlays if it is willing to devote increasing amounts of resources to enforcement, and is willing to try to block the efforts of both providers and Medicare recipients who want to avert the controls. But the "opportunity cost" of such an approach is the efficiency that could be obtained if both providers and Medicare recipients had positive incentives to improve both the quality and the cost-effectiveness of medical services. The objection to controls is not the amount of the savings, but the method of getting there. A competitive approach could create strong incentives for patients to choose health care or

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[2] *President's FY 1998 Budget: Medicare Savings and Investment Proposals, Background Materials*, February 1997. Decimals do not equal due to rounding.

[3] Medical markets can be defined for numerous medical providers, types of procedures, and for different geographical locations, so it is likely that specific Medicare controls have had different effects in different markets, and even no effect in some markets.

[4] Any economist can be expected to point out that the effects of direct controls are not the same if a market is less than perfectly competitive. That is theoretically correct, and I will *not* argue that: medical markets are perfectly competitive; that monopoly power may not exist in some contemporary medical markets; or that the extent of monopoly power did not exist in medical markets in the past. For today's policy discussions, I think it is reasonable to look on most medical markets as highly competitive. Two AEI studies present evidence relating to the competitiveness of medical markets: H.E. Frech, III, *Competition & Monopoly in Medical Care*, Washington, D.C.: The AEI Press, 1996; and Michael A. Morrisey, *Cost Shifting in Health Care*, Washington, D.C.: The AEI Press, 1994.

health plans on the basis of quality and value. And, at the same time, providers would have the incentive to compete for patients on the basis of quality, service convenience, and value. Meanwhile, the agency administering the program has a much easier time with enforcement.

2. *The failure to deal with Medicare's long-term demographic problem*: Much has been written and said about what will happen to Medicare once the baby boom generation begins to become eligible for Medicare after 2010. But in my view, nothing is more alarming than the last report of the HI trustees, a document typically known for its dry and technical language. Some examples follow:

The HI program remains severely out of financial balance. As we have said since 1992, we must report that the HI trust fund does not meet even our short-range test of financial adequacy.

The long-range outlook also remains extremely unfavorable. The trust fund fails by a wide margin to meet our long-range test of close actuarial balance, . . . To bring the HI program into actuarial balance, over just the next 25 years under the intermediate assumptions, would require either that outlays be reduced by 39 percent or that income be increased by 63 percent (or some combination of the two) throughout this 25-year period.

. . ., substantially stronger steps will be needed to prevent trust fund depletion after 2010 as the baby boom generation reaches age 65 and starts receiving benefits. At that time, the ratio of workers to HI beneficiaries, currently about 4 to 1, is projected to begin declining rapidly to a ratio of about 2 to 1.[5]

My own way of illustrating the magnitude of Medicare's problem is to convert trust fund reports' income and cost figures as a percent of payroll into actual dollar amounts and look at the annual difference between Medicare projected revenues and expenses. Based on the latest Trustees Report, these annual differences are:

2000	$48 billion
2005	$91 billion
2010	$154 billion
2015	$268 billion
2020	$456 billion[6]

[6] Intermediate projections of the *1996 HI Trustees' Report,* Table II.E2; Payroll figures from the Office of the Actuary, HCFA.

By whatever standard you want to use, these are large numbers. They illustrate the size of the problem that we have, a problem so large that we need to get started on finding a solution now rather than wait until 2007. We now have about 13 years to start our transition into a different kind of Medicare program. Waiting even five years to start the transition to a new program will make it even more difficult to achieve efficient reform. Whether we choose direct controls or competitive reforms, all providers and consumers will experience large changes in the way Medicare operates. The sooner we get started, the easier it will be.

Another aspect of this failure to face up to the long-term problem with Medicare is the one item proposed in the President's budget to extend the solvency of the Part A trust fund, the transfer of home health care from Part A to Part B. The Administration has defended this on the basis that the home health benefit is more like Part B benefits so should be part of that program.

I think focusing on where the home health benefit should be misses the main point. The most important effect of this proposal is on the source of funding for Medicare. Since the payroll tax now funding Part A is not reduced, and the Part B premium is not increased, the net effect of the transfer of the program is to transfer general funds from the overall budget to Part A. This has the effect of further reducing the discretionary portion of the federal budget. Regardless of where home health care is located, is this shift of the sources of funding in the best interest of taxpayers?

Conclusion

There are numerous policies that have been proposed to start us down the road to efficient market reform of the Medicare program. My own preference is that we should adopt a defined contribution plan for Medicare and let Congress decide how much they want to spend on it. I do not think such a system has to penalize the poor, but it would require us to be explicit about the cost.

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[5] All three quotes taken from the *1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* p. 15.

Unlike direct controls, all such proposals seek to create a more competitive health care market and give consumers stronger incentives to choose among competing plans. If the profession of economics has anything to contribute to this debate, it should be that no one can predict exactly what should be the most efficient method of delivering, organizing, and financing health care in the future. The best we can do is try to create the right incentives so all players in these markets will attempt to adjust their behavior to meet the needs of consumers. We know from economic history that competitive markets are much more efficient than the political process in finding out the most efficient way to satisfy consumers. It is time we started down that road.

Chairman THOMAS. Thank you, Mr. Helms.
Ms. Davis.

STATEMENT OF KAREN DAVIS, PRESIDENT, COMMONWEALTH FUND, NEW YORK, NEW YORK

Ms. DAVIS. Thank you, Mr. Chairman.

I am delighted to be here to testify on the President's Medicare proposal and to look at it in the context of the long-term changes in Medicare that are required.

I would like to highlight some points that are in a set of charts at the back of my statement. In chart 1, the Subcommittee has discussed the fact that the elderly pay 21 percent of their income now on health expenses. I would point out that for low-income beneficiaries, even with Medicaid supplementation, the average they spent out of income is 30 percent.

Chart 2 points out that the Medicare benefit package has deteriorated over time and not kept pace with certainly what employer plans have been doing. For example, in 1966 when Medicare was introduced, the part A deductible was $40; in current dollars, that would be $190. But because we have indexed it to the cost of hospital care, the elderly pay $736 for a hospital stay. The part B premium when it started was $3 a month; in today's terms, that would be $171, but in fact, we charge beneficiaries $510 a person. The elderly are paying more now than they paid when the program started, and benefits for the most part have not been improved. Ninety-five percent of employer plans, for example, cover prescription drugs, which Medicare does not.

Chart 3 notes that the amount that beneficiaries now pay for their own health care expenses is $2,600 per person.

Chart 4 shows the distribution of the cost to Medicare of beneficiaries, depending upon how sick they are. The sickest 10 percent of beneficiaries cost the Medicare Program $37,000 per person. The healthiest 20 percent incur no Medicare expenses. The mean is $4,700 per person.

This has tremendous implications for managed care. If we set a capitation payment based on the mean, HMOs will make money if they enroll beneficiaries who are in the healthiest 80 percent, and they will lose money if they enroll the sicker beneficiaries. It is those that they tend not to enroll and that cost the Medicare Program.

But the point I make in chart 5 is that those 10 percent of beneficiaries who are the sickest are also the ones who are paying the

most themselves. They spend $8,800 per person on average for their own health expenses.

In chart 6 we have mentioned that Medicaid is there to pick up the premiums and the cost sharing for the Medicare beneficiaries with incomes below poverty. I would say two things about that. First, only about two-thirds of those eligible are participating. It is a little like Medicaid children who are eligible but not enrolled, so we are not getting to all the elderly who are eligible for this.

But the other thing I would just remind the Subcommittee is that the poverty level for a single elderly person is $7,500, so you are talking about beneficiaries above that amount having to pay these out-of-pocket costs. And the premium subsidies under the SLMB Program only go to 120 percent of poverty, so we are really only protecting beneficiaries up to about $9,000 income, and these out-of-pocket costs are very high for a beneficiary with a $10,000 or $15,000 income.

Chart 7 just looks at the history on how Medicare expenses per person have grown compared with private. Medicare did better in the late eighties. Private insurance expenditure growth has been the same or a little better in the early nineties.

Chart 8 is the CBO projections on managed care enrollment. We are expecting a lot of growth in Medicare managed care enrollment, and therefore, some of the changes in the President's budget to change the way HMOs are paid, to tighten up on that because there is overpayment, are worthy of consideration by the Subcommittee.

I raise some of my concerns about vouchers or moving toward a defined contribution approach to Medicare, which would put beneficiaries at risk. Instead, in the long run, we certainly need to think about improving Medicare benefits, improving protection for low-income Medicare beneficiaries, moving forward with the structural reforms, such as prospective payment for all Medicare services and reforming the Medicare managed care options, particularly providing better information to beneficiaries and setting better quality standards, which the Health Care Financing Administration is beginning to do but which I think are really currently in a very rudimentary stage.

Thank you.

[The prepared statement follows:]

Statement of Karen Davis, President, Commonwealth Fund, New York, New York

Thank you, Mr. Chairman, for this opportunity to testify on budgetary savings to the Medicare program and considerations that should shape long-term changes in the Medicare program. Medicare has brought health and economic security to elderly Americans for over 30 years. Before it was enacted half of older Americans were uninsured, leaving them and their families at risk of financial catastrophe in the face of major illness. Medicare has improved access to health care, contributed to better health for millions of elderly Americans, and protected against the financial hardship of medical expenses. These fundamental goals should be preserved.

Consideration of Medicare budgetary savings should be in the context of desired long-run changes to assure Medicare better meets the needs of an aging population in the 21st century, encourages preventive care, promotes efficiency, and adapts to the changing American health care delivery system. Principal issues include:

- Medicare premiums, cost sharing, and benefits
- Prospective payment methods for all health care providers
- Medicare's managed care options
- Financial solvency.

Medicare Premiums, Cost Sharing, and Benefits

The President's budget protects beneficiaries from additional out-of-pocket costs for health care. The President's five-year budget proposal includes:

- $10 billion savings from holding the Part B premium at 25 percent of outlays
- A cost of $7 billion for gradually reducing the coinsurance on hospital outpatient care to 20 percent from 46 percent currently
- A cost of $6 billion for improved preventive services coverage and an Alzheimer's respite benefit.

The net impact on beneficiaries is about a wash—although some beneficiaries will pay slightly more than under current law, and some will have out-of-pocket costs reduced.

Concern for beneficiary financial burdens is appropriate. About three-fourths of all Medicare beneficiaries have incomes below $25,000. On average Medicare beneficiaries already spend 21 percent of their income on health care. For those with incomes below the poverty level, elderly beneficiaries spend 30 percent of income on health care.[1]

These high costs come in large part because the Medicare benefit package has deteriorated rather than improved over the last 30 years. The structure of benefits is fundamentally the same today as it was when it was implemented, but cost-sharing is considerably higher. In 1966 the hospital deductible was $40 ($190 in 1996 dollars); in 1996 it was $736. The deductible for Part B (Supplementary Medical Insurance) services is $100, also up from $50 in 1966, but lower in current dollars than it was in 1966 ($238 in 1996 dollars). The Part B premium was originally set at $36 ($171 in 1996 dollars), representing 50% of SMI outlays; in 1996 it was $510 a year representing 25% of program outlays. These premiums and cost-sharing are also higher than faced by most workers. In addition most employer plans include a ceiling on out-of-pocket expenses; Medicare does not.

The Medicare benefit package is essentially unchanged over the last 30 years. The only major new services include hospice care, rural health clinics, drug coverage for immunosuppressive drugs, erythropoietin for persons with chronic kidney failure, outpatient chemotherapy, and some limited preventive services (subject to the Part B deductible and 20% coinsurance).

The application of cost-sharing to preventive services such as mammograms has restricted access to this service, especially for those without supplemental coverage to Medicare. A recent study supported by The Commonwealth Fund found that elderly women without Medicaid or supplemental private health insurance were much less likely to get mammograms.[2] The financial barriers posed by deductibles and coinsurance for cancer screening contribute to failure to detect cancer in an early stage when recovery chances are higher.

Medicare does not cover prescription drugs (covered by 95 percent of employer plans). Not covered, for example, are insulin, cholesterol-lowering drugs, hormone replacement therapy medication, and pain medication for cancer patients. Medicare also has limited long-term care benefits (only 16 percent of nursing home and home health care is paid by Medicare; another 38 percent is paid by Medicaid.[3]

The high cost-sharing and limited benefits expose seriously ill Medicare beneficiaries to high out-of-pocket costs. In 1996 Medicare beneficiaries paid $2,605 per person for their own health care costs. Medicare expenditures and out-of-pocket costs, however, are highly skewed. The sickest 10 percent account for 75 percent of Medicare outlays. In 1996 the sickest 10 percent of Medicare beneficiaries averaged $37,000 in Medicare outlays; the healthiest 20 percent incur no Medicare expenses.[4]

But the sickest beneficiaries also spent the most themselves. Their out-of-pocket costs for Medicare covered services was $5,600, and their out-of-pocket costs for all health services was $8,800. Any increase in cost-sharing would fall disproportionately on these beneficiaries and add to this considerable financial burden.

Since a major purpose of Medicare is to provide financial protection for beneficiaries, a good case could be made for improving benefits, lowering cost-sharing, and raising premiums in the long-term. This would improve financial protection, especially for the 10 percent of Medicare beneficiaries who have no supplemental re-

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[1] Marilyn Moon, Crystal Kuntz, and Laurie Pounder, *Protecting Low-Income Medicare Beneficiaries,* The Commonwealth Fund, December 1996.

[2] Janice Blustein, "Medicare Coverage, Supplemental Insurance, and the Use of Mammography by Older Women," *New England Journal of Medicine* 332:1138–1143, April 27, 1995.

[3] Harriet L. Komisar, Jeanne M. Lambrew, and Judith Feder, *Long-Term Care for the Elderly,* The Commonwealth Fund, December 1996.

[4] Marilyn Moon, *Restructuring Medicare's Cost-Sharing,* The Commonwealth Fund, December 1996.

tiree or Medigap coverage and for those chronically ill Medicare beneficiaries with major health care expenses.

One possibility would be giving Medicare beneficiaries the choice of a comprehensive benefit package with little or no cost-sharing and a commensurately higher premium so that beneficiaries would not be forced to purchase costly private MediGap coverage. With some important exceptions, MediGap plans often deny coverage to elderly people with pre-existing conditions. MediGap plans are required by federal law to limit administrative costs to 40 percent for individual plans and 25 percent for groups plans; yet in 1993, 38 percent of plans did not comply with minimum loss ratio standards.[5] Combining supplemental coverage with Medicare into a single comprehensive Medicare benefit package would lower administrative costs, reduce paperwork burdens, and the necessity of coordinating Medicare and MediGap payment. At a minimum MediGap plans should be required to accept all Medicare beneficiaries without underwriting, excluding bad risks, or charging higher premiums to sick or very old beneficiaries.

Low-income elderly and disabled beneficiaries have increasingly relied on the Medicaid program to supplement their Medicare benefits. The Qualified Medicare Beneficiary (QMB) program entitles all poor Medicare beneficiaries to supplemental Medicaid coverage to pick up cost-sharing and premiums. Beneficiaries with incomes up to 120 percent of the poverty level are eligible for Medicare Part B premium subsidies from Medicaid (Specified Low-Income Medicare Beneficiary [SLMB] program). These provisions are quite modest. The poverty level for a single elderly person in 1996 was $7,525 and $9,484 for a couple.

Only about two-thirds of those eligible for QMB coverage, however, participate, and only about 10 percent of those eligible for SLMB do so.[6] A Commonwealth Fund study found that the most common reasons why elderly poor are not covered by public benefit programs are that they are unfamiliar with the programs or do not think they are eligible.[7] Better outreach to those who are qualified for Medicaid supplementation to Medicare is important.

Poor and near-poor elderly are more likely to be experiencing health problems that require medical services than elderly people who are economically better off. Yet, they are less able to afford needed care because of their lower incomes. For those who do get care, large out-of-pocket medical expenses can lead to impoverishment.

Medicaid could be improved to assure better benefits and financial protection for low-income Medicare beneficiaries. Federalizing this portion of Medicaid, improving supplemental coverage (including prescription drugs), and increasing eligibility to, say, 150 percent of poverty are options worthy of exploration. Federalization of the QMB and SLMB programs would permit better coordination with Medicare and likely increase participation of those eligible.

In short the President's budget represents modest steps toward improving benefits and protecting beneficiaries financially. It provides for annual mammograms without cost-sharing. It provides respite benefits for families of Alzheimer's patients. But more significant steps over the long-term will be required to modernize the Medicare benefit package, including prescription drugs, lower cost-sharing, and assure the adequacy of supplemental coverage for poor and near-poor beneficiaries.

Provider Payment

The President's budget obtains the bulk of its projected five year savings by tightening provider payments: $33 billion from hospitals, $7 billion from physicians and other practitioners, $14 billion from home health agencies, $7 billion from skilled nursing facilities, $2 billion from other providers, and $9 billion from measures to curb fraud and abuse.

The extent to which Medicare can tighten payments to providers without jeopardizing access to quality services for beneficiaries and introducing serious financial instability in the health sector is a judgment that is difficult to make with any precision. As a general principle Medicare can not depart too fundamentally from payment rates in the private sector without risking the deterioration of its fee-for-service coverage.

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[5] General Accounting Office, *MediGap Insurance: Insurers' Compliance with Federal Minimum Loss Ratio Standards,* 1988–1993, August 1995.

[6] Marilyn Moon, Crystal Kuntz, and Laurie Pounder, *Protecting Low-Income Medicare Beneficiaries,* The Commonwealth Fund, December 1996.

[7] The Commonwealth Fund Commission on Elderly People Living Alone, *Old, Alone, and Poor,* April 1987.

Because Medicare is a major source of revenues to health care providers, nearly all qualified health care providers and increasingly nearly all HMOs have opted to participate—despite the fact that payment rates have historically been set by Medicare below private sector rates. In the last few years managed care plans have followed Medicare's practice of using significant purchasing power to obtain "price discounts" from providers.

Medicare has been an innovator in provider payment. Its system of physician payment has been increasingly accepted by physicians as payment in full. Its innovations in physician payment in fact have contributed to the growth of managed care plans who use it as a basis for establishing fee schedules for physicians participating in discounted fee-for-service managed care plans. A survey of managed care plans finds that Medicare still obtains the best "discounts" from physicians—with most managed care plans paying physicians in excess of Medicare rates.[8]

A good comparison of the performance of Medicare and private coverage for the working population is difficult because of the age differences in those it covers. Instead analysts have focused on comparing the rates of increase in Medicare and private sector outlays. Prior to the mid-1980s both Medicare and private health expenditures grew rapidly, with Medicare growing slightly faster. Starting with the introduction of prospective payment for hospitals, Medicare grew more slowly than private health expenditures in the mid-1980s to early 1990s.[9] Employers complained regularly that Medicare was "cost-shifting" to the private sector because it achieved price "discounts" from hospitals and physicians.

The development of private sector managed care plans that used their collective purchasing power to obtain price discounts appears to have moderated the growth in employer premiums in the 1990s. Recent reports suggest, however, that this period of moderation may now be ending, as both Medicare and private plans become subject to the underlying forces that have driven health care costs historically—labor-intensive services and improving health care technology.

Over the long run both Medicare and private health insurance are driven by underlying trends in health care costs. A sustainable rate of growth of Medicare outlays, therefore, is one that assures that Medicare expenditures per capita adjusted for the aging of the population grows over the long-term at the same rate as the rest of the health sector. Otherwise the quality and accessibility of services under Medicare are likely to deteriorate relative to that of other patients. To define "sustainability" as a rate of growth of Medicare outlays that obviates the need to increase taxes or increase beneficiary financial contributions is to ignore the fundamental goal that Medicare is trying to achieve—access to quality health care services and financial security for beneficiaries.

Rather than continue the attack on Medicare's fee-for-service option, it is important that the innovations of prospective payment for hospitals and physicians be extended to other Medicare services. Growth in Medicare hospital and physician expenditures have moderated considerably. The major areas where Medicare is now growing rapidly are for those services not covered by prospective payment approaches—particularly home health, skilled nursing facilities services, subacute hospital care, and hospital outpatient care. Developing new methods of prospective payment for these services should be a top priority, and the President's budget recommends steps in this direction. Other techniques such as profiling patterns of utilization of different physicians, appropriateness guidelines, and high cost case management may also generate further savings.

Nor should we lose sight of the fact that growth in health care spending nationally and in Medicare have brought improvements in life expectancy and quality of life. Life expectancy at age 65 has increased by three years since Medicare was enacted, and the U.S. is a world-leader in life expectancy of older adults. Technological innovations such as cataract surgery, joint replacements, and advanced methods of treating coronary artery disease have prolonged life and improved functioning for millions of Americans. Medicare, in particular, has contributed to technological advances not only by directly financing health care for older Americans but through payments to academic health centers which are on the forefront of developing and testing new advances in medicine.

Medicare's Managed Care Choices

The President's budget also proposes to achieve $34 billion over five years in savings under its managed care options. This is to be achieved by: tightening fee-for-

[8] Physician Payment Review Commission, *Annual Report to Congress* 1995, p. 83.

[9] Marilyn Moon and Stephen Zuckerman, *Are Private Insurers Really Controlling Spending Better than Medicare?* The Urban Institute, July 1995.

service provider payments, which lowers the managed care capitation rate ($18 billion); a proposal to lower the capitation rate from 95 percent to 90 percent of the fee-for-service cost ($6 billion); removing the allowance for teaching and disproportionate share from the managed care capitation rate ($10 billion); and reducing the wide geographic disparities in the payment rates (budget neutral). In addition, the proposal would expand the kinds of managed care plans eligible to participate in Medicare.

Managed care plans are aggressively marketing to Medicare beneficiaries. Medicare permits qualified health maintenance organizations, including point of service plans, to participate in the program. Seventy percent of HMOs offer coverage to Medicare beneficiaries. Currently 10 percent of Medicare beneficiaries enroll in HMOs, but this number is growing rapidly. The Congressional Budget Office estimates that by the year 2000, 20 percent of Medicare beneficiaries will belong to HMOs.[10]

Genuine choices between quality managed care and fee-for-service care for Medicare beneficiaries are important to preserve over the long-term. Fee-for-service care has the disadvantage of creating incentives for too much care at too high cost; managed care has the disadvantage of creating incentives for too little care at substandard quality. Providing a genuine informed choice for beneficiaries of both options may counter the harmful consequences of either extreme. If either part of the program deteriorates in the quality and level of service available, neither beneficiaries nor the government will be well served. Careful attention, however, will need to be paid to issues of risk selection since sicker beneficiaries are more likely to opt for fee-for-service coverage while healthier beneficiaries are more likely to enroll in managed care plans.

While most Medicare beneficiaries have managed care options available to them, familiarity with this option is not widespread. Medicare could systematically make information available to beneficiaries about choices in their geographic area, and conduct a formal annual enrollment process.

It is important, however, that managed care plans be held to high quality standards. A recent study finding that health outcomes of elderly patients worsen under managed care compared to fee-for-service care is particularly troubling.[11] There may also be a significant downside to managed care enrollment that requires beneficiaries to change physicians. A study supported by The Commonwealth Fund found that continuity of care from retaining the same physician for a long period of time has benefits. Medicare beneficiaries who had seen the same physician for ten or more years had fewer hospitalizations and lower Medicare costs.[12]

Starting slowly is important. Expanding coverage to loosely organized managed care plans such as preferred provider organizations does not seem warranted, until many of the problems with current capitation payment are resolved and adequate quality standards established and an enforcement mechanism instituted. The Health Care Financing Administration is taking important steps to require that participating managed care plans provide standardized information on quality indicators, but an effective quality information and assurance system is a long way from realization. Nor does the program as yet require accreditation of HMOs. One protection for beneficiaries is the right to disenroll from a managed care plan on a monthly basis. This ability to "vote with their feet" is an important protection until better quality standards are in place.

Even if enrollment in managed care plans were to expand more rapidly, it would not yield savings to the program. The best study on the issue finds that the actual cost of serving Medicare beneficiaries who opt for HMO enrollment is 5.7 percent more than Medicare would have paid for these same beneficiaries had they been covered under fee-for-service Medicare coverage.[13] Instead of saving Medicare money, the program loses almost 6 percent for every Medicare managed care enrollee.

Nor is there compelling evidence that managed care generates health system savings over the long term. Most savings such as price discounts or reduced hospitalization are one-time savings and do not offset the rate of increase over time. Managed

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[10] Congressional Budget Office, *January 1997 Baseline: Medicare/Medicaid,* January 18, 1997.

[11] John E. Ware, Jr., Martha S. Bayliss, William H. Rogers, Mark Kosinski, and Alvin R. Tarlov, "Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results From the Medical Outcomes Study," *Journal of the American Medical Association* 276:1039–1047, October 2, 1996.

[12] Linda J. Weiss and Jan Blustein, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans," *American Journal of Public Health,* December 1996.

[13] R. Brown et al., *The Medicare Risk Program for HMOs: Final Summary Report on Findings from the Evaluation,* Mathematica Policy Research, February 18, 1993.

care administration costs, furthermore, average 15 to 20 percent, compared with Medicare's 2 percent administration costs.

Medicare loses money on managed care to the extent that plans enroll and retain healthier than average beneficiaries. Given the extreme variability in health outlays among beneficiaries, there is great leeway for plans to select relatively healthier beneficiaries for whom capitated rates exceed true costs. If managed care plans succeed in attracting and retaining relatively healthier Medicare beneficiaries (which they have very strong incentives to do), Medicare will be overpaying for those under managed care, and yet paying the full cost of the sickest Medicare beneficiaries who are unattractive to managed care plans. Managed care plans have the option of switching out of the risk contract program if they experience adverse selection.

The current method of paying managed care plans for Medicare patients is seriously flawed. Its primary weakness is that it does not adequately adjust for differences in the health status of beneficiaries. Unfortunately, a good method of setting capitation rates to adjust for differences in beneficiary health status still seems years away.

Tying Medicare HMO payment rates to local fee-for-service experience is neither equitable nor tenable in the long-term. A national rate with appropriate geographic adjustment for differences in the cost of practice would be preferable. However, rates are currently so widely variable across geographic areas that a long transition period will be required.

The current method of Medicare HMO payment includes allowances for the direct and indirect costs of medical education, even though managed care plans do not incur these costs; The payment rate also includes an allowance for disproportionate share payments even though managed care plans do not cover the uninsured, and in general are open only to those who can afford the premium or have employers or public programs that pay the premium on their behalf.

It makes little sense to overpay HMOs and encourage Medicare beneficiaries to enroll, yet have the program lose money on each beneficiary who enrolls. If adequate measures to adjust for health status can not be developed in the short run, serious consideration should be given to lowering the Medicare HMO payment rate. It is currently set at 95 percent of Medicare projected expenditures for beneficiaries with average health status. Given the favorable selection that occurs, reducing this to 85 to 90 percent could be considered.

The extent of managed care abuses could be curbed by lowering capitation payment rates and imposing penalties on plans for high disenrollment rates, but the basic underlying incentives are unlikely to be substantially altered. Nor has the long-term success of managed care in controlling costs while providing quality care to seriously ill patients yet been demonstrated. Proceeding cautiously and slowly is in order.

Vouchers, Medical Savings Accounts, Catastrophic Coverage

Another approach is to convert Medicare from a defined benefit program to a defined contribution program. Currently, Medicare sets payments to hospitals and HMOs; this payment is payment in full. Hospitals and HMOs may not charge beneficiaries on top of what Medicare pays. Physicians have strict limits on balance billing over the fee schedule (no more than 15 percent above the fee schedule); and about 90 percent of all claims are now assigned. Most defined contribution approaches would eliminate this feature and permit managed care plans and health care providers to set their own charges, with beneficiaries financially at risk for the difference between a fixed voucher and what providers and health plans charge.

In a difficult federal budgetary climate, capping the federal budget obligation for Medicare on first examination has appeal as a policy option. Vouchers or giving beneficiaries the actuarial value of Medicare to purchase private coverage permits the government to control its expenditures regardless of the trend in health care costs. However, this approach shifts financial risks to beneficiaries, and undermines the financial security that Medicare is intended to provide. By freeing managed care plans, hospitals, and physicians to charge whatever they choose in the marketplace, the benefit of the large purchasing power that Medicare has, as well as the governmental authority it represents, no longer would be available to help beneficiaries obtain care at lower cost.

Proposals to change Medicare into catastrophic coverage with, for example, a $2,500 combined deductible could pose major barriers to care for low-and modest-income beneficiaries. A high deductible with no ceiling on out-of-pocket costs is especially of concern.

Vouchers to purchase catastrophic health coverage with the balance invested in medical savings accounts raise particular concerns. Such provisions are likely to be

costly to the Medicare program. While a mandatory voucher system could be designed to guarantee savings, a voluntary voucher program is almost certain to be attractive only to relatively healthier beneficiaries. Setting the voucher at an average level could result in very substantial overpayments. Medicare currently spends very little on the healthiest 50 percent of Medicare beneficiaries. If they were to take vouchers, the cost to the program could be extraordinary. Skimming off the healthiest Medicare beneficiaries undermines the advantages of risk pooling that Medicare as a universal program now achieves.

The most serious potential problem with vouchers is that the market would begin to divide beneficiaries in ways that put the most vulnerable beneficiaries—those in poor health and with modest incomes—at particular risk. If vouchers or other types of specialized plans like medical savings accounts skim off the healthier, wealthier beneficiaries, many Medicare enrollees who now have reasonable coverage for acute care costs, but who are the less desirable risks, would face much higher costs due to the market segmentation. A two-tier system of care could result in which modest income families are forced to choose less desirable plans.

Catastrophic coverage is unlikely to be attractive to many beneficiaries. After all, 90 percent of Medicare beneficiaries now obtain supplemental coverage to avoid the $736 Part A deductible and $100 Part B deductible. Few beneficiaries who truly understand that a plan has a $5,000 or $6,000 annual deductible are likely to find it attractive. Many of the chronically ill would be required to pay this deductible not just once, but year after year. Nor is it affordable for the three-fourths of Medicare beneficiaries with incomes below $25,000. If beneficiaries were to experience a serious illness, they could face financial bankruptcy and bad debts to providers. Providing financial protection for beneficiaries was the major rationale for creating Medicare. It should not be abandoned now.

Further, the experience with sale of private MediGap coverage to beneficiaries is that without stringent safeguards, marketing abuses are likely. Confused or scared, some beneficiaries could take options which are not in their best interests—nor genuinely preferred by them.

On balance, vouchers offer little in the way of guarantees for continued protection under Medicare. Further, the federal government's role in influencing the course of our health care system would be substantially diminished. For some, this is a major positive advantage of such reforms. But the history of Medicare is one in which the public sector has often played a positive role as well, first insuring those largely rejected by the private sector and then leading the way in many cost containment efforts. But most troubling is the likelihood that the principle of offering a universal benefit afforded by social insurance would be seriously undermined.

Financing Medicare in the 21st Century

The President's budget would ensure the solvency of the Part A Trust Fund until the year 2007 by shifting about half of home health services from Part A to Part B. While this has been criticized as an accounting "gimmick," there are sound analytic and pragmatic reasons for making this shift.

Pragmatically, the alternative short-term options for preventing the looming exhaustion of the Part A Trust Fund come down to: increasing beneficiary cost-sharing for hospital and other Part A services, tightening provider payments substantially further than those contained in the President's budget, and increasing payroll taxes. The deductible for Part A services is already exorbitant ($736 in 1996) and cost-sharing already falls heavily on those who are seriously ill enough to incur a hospitalization or need post-acute services such as home health or skilled nursing facility services. There is a limit to how rapidly the health sector can adjust to tighter provider payment rates, and how sharply Medicare can curtail provider payment rates relative to the private sector.

The fiscal problem of the Hospital Insurance Trust Fund is directly related to the fact that hospital, home health, and skilled nursing facility care are financed by a payroll tax, while general tax revenues and beneficiary premiums are used to finance ambulatory care. The payroll tax will always fall short of covering Medicare hospital and post-acute care outlays—for the simple reason that the number of older people is growing faster than the number of workers and health care costs historically go up faster than earnings. According to the Congressional Budget Office, the Hospital Insurance Trust Fund could be solvent for an additional 25 years if the payroll tax were increased by an additional 0.65 percent on both employers and

workers (from 1.45 percent now).[14] More modest increases of, for example, 0.15 percent on both employers and workers, would generate about $10 billion annually.

Analytically, there is no reason why hospital and post-acute care benefits for the elderly should be financed by a payroll tax and physician and other ambulatory services should be financed by general revenues and premiums. Nor does it make much sense that visits by a nurse to the home should be paid for by a payroll tax while visits to the home by a physician should be paid for by general revenues and premiums.

The real issue is the rapid growth of home health spending in recent years, and what changes in the Medicare program would help assure that appropriate services are being provided efficiently. Changing from cost reimbursement to prospective payment is an important improvement. But the levels of service vary widely across geographic areas and by type of home health agency. For-profit agencies provide twice as many home health visits per beneficiary as nonprofit agencies.[15] Home health visits annually range from over 24,000 per enrollee in Louisiana to less than 3,000 in Wisconsin.[16] Setting guidelines for numbers of services based on patient health or functional status, and perhaps establishing an overall expenditure target such as the Volume Performance Standard incorporated in the prospective payment system for physicians are worthy of exploration.

Shifting some or all of home health services into Part B creates an opportunity to apply methods appropriate to ambulatory services to home health care. By making a one-time reduction in the fiscal burden on Part A it also provides much-needed time to address the more fundamental problems created by the division of Medicare into Part A and Part B.

In the long-term it will be imperative to make changes in the way Medicare is financed. Division into two parts is a historical artifact. In part the division arose from the fact that it was modeled on Blue Cross (BC)/Blue Shield (BS) plans which separately covered hospital and physician services; subsequently most BC and BS plans have merged, but Medicare has not. Another reason that Medicare has two parts is that Part B was tacked on late in the legislative process as a political compromise. Whatever its origins, it is fair to say that the dual structure serves little useful purpose today and is even counterproductive.

How we choose to finance Medicare benefits is a policy choice, not a given dictated by history. Merging Part A and Part B into a single Trust Fund would improve the rational operation of the program, especially as managed care grows. With managed care providing both hospital and physician services, a combined benefit makes more sense. A single ceiling on out-of-pocket expenses is also facilitated by a single benefit.

In the long-run, payroll taxes may not be the best source of financing Medicare. It would be useful to have a revenue source that grows automatically as the population ages—whether that is greater reliance on general revenues, new taxes such as consumption taxes or value added taxes, a health sector tax, or greater taxes on the elderly (e.g., taxing the actuarial value of Medicare or an income-related Medicare premium). Payroll taxes can continue to be a portion of financing, but will always generate periodic crises as Medicare expenditures outstrip payroll tax revenues.

Nor can Medicare's long term problems be solved by raising the age of eligibility for Medicare. Employer retiree health benefits have been dropping precipitously in the last decade. Today only about one-third of retirees have such coverage. Early retirees between the ages of 55 and 64 are already at risk, and those with major health problems find it difficult to obtain affordable coverage.[17] Consideration should be given to permitting those under age 65 to purchase Medicare coverage. Subsidies may be required for low and modest income retirees to make such coverage affordable. Raising the age of Medicare eligibility would exacerbate this already serious problem.

Building on Medicare's Strengths

At present, too little attention is being focused on how to improve the functioning of the Medicare program, rather than departing radically from its basic structure.

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[14] June E. O'Neil, "The Financial Status of the Medicare Program," testimony before the Committee on Ways and Means, U.S. House of Representatives, May 2, 1995.

[15] General Accounting Office, *Medicare: Home Health Expands While Program Controls Deteriorate,* March 27, 1996.

[16] Genevieve Kenney and Marilyn Moon, "Reining in the Growth in Home Health Services under Medicare," draft report to The Commonwealth Fund, February 1997.

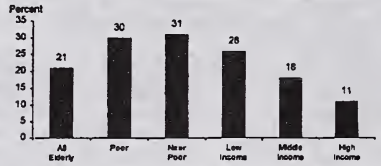
[17] Pamela Loprest and Cori Uccello, *Uninsured Older Adults: Implications for Changing Medicare Eligibility,* The Commonwealth Fund, January 1997.

The goal should be preserving genuine choice for all Medicare beneficiaries to be cared for by physicians or a health system of their choice while guaranteeing quality care at a reasonable cost to beneficiaries and to taxpayers. Steps can be taken in the short-term to: 1) improve benefits and financial protection for beneficiaries; 2) institute prospective payment methods for all Medicare services; 3) improve Medicare's payment system for managed care plans, set and enforce quality standards, provide standardized information to beneficiaries, and manage an annual enrollment process with genuine choices for beneficiaries; and 4) extend the solvency of the Part A Trust Fund while beginning an indepth examination of the merits of alternative sources of financing Medicare over the long term.

What should be preserved is the essential role that Medicare plays in guaranteeing access to health care services and protecting from the financial hardship that inadequate insurance can generate for our nation's most vulnerable elderly and disabled people. No American should become destitute because of uncovered medical bills nor be denied access to essential health care services. Medicare is a model of success. It should be strengthened and improved, and any fundamental restructuring should occur only after a full array of options is carefully analyzed, critiqued, and debated.

Thank you.

Out-of-Pocket Health Spending by the Noninstitutionalized Elderly as a Percent of Family Income, 1996



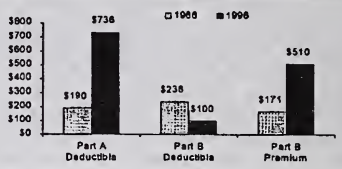
Poverty status definitions: poor=<100% of poverty; near poor=100-125%; low income=125-200%; middle income=200-400%; and high income=400%+

Source: Marilyn Moon et al., *Protecting Low-Income Medicare Beneficiaries*, The Commonwealth Fund, December 1996.

Chart 1

THE COMMONWEALTH FUND

Medicare Cost Sharing, 1966 and 1996 (in 1996 dollars)

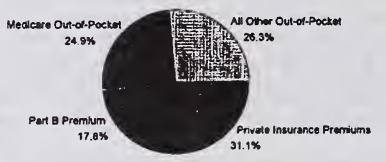


Source: Calculated by Karen Davis, based on U.S. House of Representatives, Committee on Ways and Means, 1996 Green Book.

Chart 2

THE COMMONWEALTH FUND

Out-of-Pocket Health Expenditures for the Noninstitutionalized Elderly, 1996 $2,605 per Beneficiary

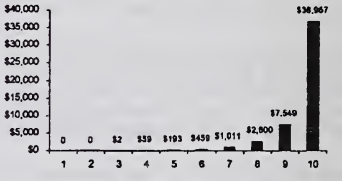


Source: Marilyn Moon et al., *Protecting Low-Income Medicare Beneficiaries*, The Commonwealth Fund, December 1996.

Chart 3

THE COMMONWEALTH FUND

Medicare Expenditures per Beneficiary by Decile of Least Costly to Most Costly, 1996 ($4,753 mean)

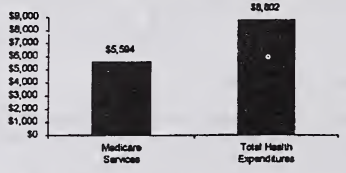


Source: Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

Chart 4

THE COMMONWEALTH FUND

Out-of-Pocket Expenditures per Beneficiary for 10 Percent Most Costly Beneficiaries, 1996

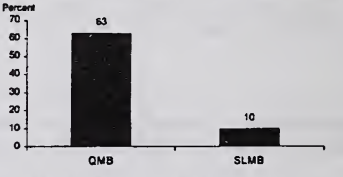


Source: Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

Chart 5

THE COMMONWEALTH FUND

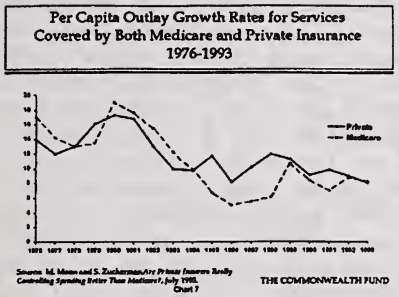
Participation in Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs, 1990

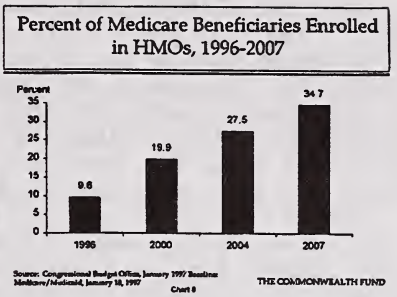


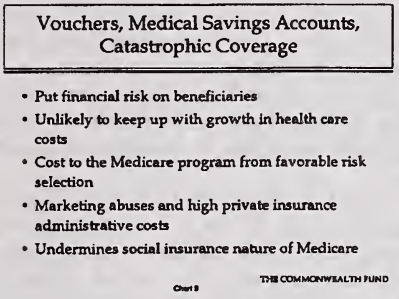
Source: Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

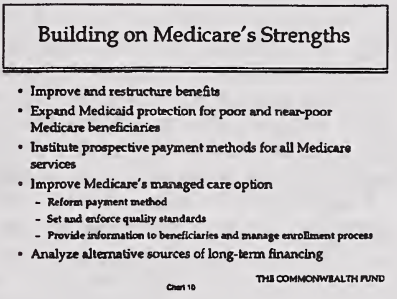
Chart 6

THE COMMONWEALTH FUND


Per Capita Outlay Growth Rates for Services Covered by Both Medicare and Private Insurance 1976-1993
Private
Medicare
THE COMMONWEALTH FUND




Vouchers, Medical Savings Accounts, Catastrophic Coverage
• Put financial risk on beneficiaries
• Unlikely to keep up with growth in health care costs
• Cost to the Medicare program from favorable risk selection
• Marketing abuses and high private insurance administrative costs
• Undermines social insurance nature of Medicare
THE COMMONWEALTH FUND


Building on Medicare's Strengths
• Improve and restructure benefits
• Expand Medicaid protection for poor and near-poor Medicare beneficiaries
• Institute prospective payment methods for all Medicare services
• Improve Medicare's managed care option
- Reform payment method
- Set and enforce quality standards
- Provide information to beneficiaries and manage enrollment process
• Analyze alternative sources of long-term financing
THE COMMONWEALTH FUND

Chairman THOMAS. Thank you, Ms. Davis.

On your chart 8—and we are going to have a hearing so that we can get CBO estimates—I notice that you use the CBO baseline for projection of percentage participation. Whether you view it as good or bad, don't you believe the changes that the President's program advocates, or any that we might adopt similar to those, would in fact change the percentages of people going into HMOs? It certainly would not make them more attractive to go into them; would you agree with that?

Ms. DAVIS. I think if you tightened up the payment rate and made it 90 percent instead of 95 percent, the HMOs would be able to offer fewer supplemental benefits, and it would be somewhat less attractive.

On the other hand, if Medicare is losing money for every person who enrolls, it makes little sense, from the government taxpaying point of view, to want more people to enroll.

I think the basic objective is to make it neutral, and one could do that by trying to find a way of adjusting the current payment rate for health status. In the absence of a good way of doing that, I think that just lowering the rate has merit.

Chairman THOMAS. And you did use the phase, "if we are paying more," and you cited a study in your written testimony about the fact that perhaps we are. I just lament—and in your written testimony, you also lament—the search for the "Holy Grail," which is a risk-adjusted mechanism that would allow us to make more objective comparisons within that structure. And it is just unfortunate that we do not have tools. I am ready for an imperfect tool if I cannot get a better tool for doing those kinds of measurements.

Also in your chart—and you alluded to the number of children who are eligible for Medicaid insurance who are not under it—similarly, seniors who are dual-eligible are not—why are we not doing a better job of getting a higher participation rate? What is it? And I ask anybody. You folks, especially Dr. Helms and you, have been in the inside business on this. Why can't we pick up a higher percentage in a program that already exists?

Ms. Davis. I think part of the problem is the Federal-State nature of Medicaid. The States do not want to pick up what they view as the Federal Government's responsibility of paying for the elderly, so they are the ones who have to go out and tell the elderly that they are eligible for this benefit, which costs the State governments money, so they view it as a mandate, as a higher cost on them.

When you look at the SLMB feature in New York City, the Medicaid officials did not have the form if somebody asked for it. It is not in the State's interest economically to make it known to these beneficiaries that this is available.

Chairman THOMAS. If the Feds would in essence hold the States harmless for any increase in the enrollment, if we are in fact going to talk about legislating in this area, either for children or for seniors, don't you think the most cost-effective way to spend Federal dollars would be to pass through and encourage the States, who are the primary contact points, to do a better job of enrolling, rather than starting Federal programs for these recipients?

Ms. DAVIS. Well, as I say, the States have an economic disincentive to do it.

Chairman THOMAS. But if we passed through and did not create that disincentive, and we held them harmless—we have a Federal dollar, we can pass it through to encourage the States to enroll more, or we can use the Federal dollar to start a program at the Federal level which in fact may cover those people who are in essence already covered. Which way would be a better way to spend that Federal dollar?

Ms. DAVIS. Well, I think for the dual beneficiaries, those who are eligible for both Medicare and Medicaid, you get problems of coordination across two programs, and there are some arguments administratively for making it a single program. But if you were to keep it as a State level, certainly, to increase the Federal share on that would be a way to give States more of an incentive to deal with it.

Mr. REISCHAUER. Can I suggest that this really is a Federal responsibility? The motivations that Karen alludes to are perfectly correct, but let us remember that the States have no idea who is on Medicare and who is not among their populations. The Federal Government does; the Federal Government sends notices saying what changes in Social Security are going to be made in the next

year, what changes in part B premiums are going to be made. It would not be hard to include in that notification a statement that if your income is below 120 percent of the poverty level, and the dollar value of that income could be given, that you could go to your State enrollment agency for Medicaid and provide an address, and you could, at a minimum, have your part B premiums paid for. If you were below poverty, you could have your deductibles and coinsurance paid as well.

I see no reason to expect the States to be the parties responsible for this kind of enrollment.

Chairman THOMAS. Karen, on your chart 1, where you break out the out-of-pocket burden and you emphasize clearly that the poor and the near poor are about 60 percent, I look at the chart and see that somewhere around 30 percent are middle income and high income.

Currently, we have a general fund contribution of about 75 percent of part B costs. It is a subsidy to everybody in part B. And your concern is with the lower end. If in fact we have this contribution, doesn't it make more sense to take the total dollars and redistribute them to increase the protection for those who are least able to pay and reduce the subsidy for those who are best able to pay?

Ms. DAVIS. I certainly agree with that. I certainly have no problem, if that is your question, with including the home health benefit in the part B premium and taking that added revenue and using it to improve the premium protection at the low income or possibly, as Mr. Reischauer suggests, an income-related premium surcharge at the very high end.

I think you want to think about the income ranges you are talking about. Twenty-six hundred dollars, which is the average for everybody, is a lot of money today for an elderly person with a $20,000 income or a $30,000 income. You have to look at how it is borne, but certainly the basic notion of having better protection at the low income, if you have got to raise more money through beneficiaries, doing it through premiums rather than cost sharing that falls on those who are very sick and if necessary, getting more money out of the high-income level.

Chairman THOMAS. Now, that changes the program, and there are a number of folks who are kind of adamant about not changing this subsidy for everybody. But as we get into the scarce dollars and looking for where and how we are spending it, I just do not understand those who will look at this chart and be willing to maintain problems at the lower end while providing a subsidy for those who, with any—400 percent of poverty income getting 75 cents out of every dollar subsidy out of the general fund is just—I do not understand why people are not willing. And the best statement we have been able to get out of the President is that he is not unopposed to looking at something like that.

Somebody—and I do not want to say on your side—but somebody has got to start talking about doing things that are prudent, like taking the fixed amount of money we currently use and spending it better. We have just got to start talking about that, or we are never going to close on problem areas.

Ms. DAVIS. Mr. Chairman, at a Ways and Means conference I think in 1984, I supported an income-related premium.

Chairman THOMAS. That is good enough; I just wanted to get something on the record.

Ms. DAVIS. The point I would make is that only 5 percent of Medicare beneficiaries have incomes over $50,000, so you are not going to generate a lot of revenue from it.

Chairman THOMAS. If it is one penny, how can you defend the kind of program that continues to do that? It is done in large part by some folks for philosophical reasons, and I think we have got to get beyond some of these philosophical standards and look at where and how scarce resources are being allocated.

Dr. Reischauer, you were talking about options that are available to us, and when you boil it down, you either raise more revenue, increase the age, or you look at the programmatic topography and talk about change which will lead to changes in the future.

I was at an AARP meeting, and one of the women said, I do not know why you did not just freeze the premium when it was at the 31.5 percent; it was just a couple of bucks for everybody, and they would not have noticed it.

It is amazing now that the administration is moving at a 25-percent freeze, and I think it is interesting that the difference between the 31.5-percent freeze and the 25-percent freeze equals at least half of the $82 billion home health transfer. The simple timing of when we froze the premiums would have cut the problem in half.

From your perspective and how you have watched the system over the years, do you think there is any chance to go back to something closer to the original 50–50, or is 25 percent in your opinion about as high as we are ever going to get unless we rethink the way in which we structure?

Mr. REISCHAUER. That is a political judgment. I guess I am optimistic——

Chairman THOMAS. Well, now that you are no longer director of the CBO, you can proffer a political judgment if you want to.

Mr. REISCHAUER. I am hopeful that the part B premium can be raised above 25 percent, particularly for those who have the capacity to pay. We have in the Medicare Program a program that subsidizes participants rather significantly. CBO's estimates are that the part B premiums and the payroll taxes paid by an average-wage individual retiring at age 65 in 1995 amounted to only 34 percent of their expected costs to this program. This is an issue of a tradeoff. Somebody is paying that subsidy. Is the person paying that subsidy, the average American taxpayer, or the average American beneficiary of some other program that is being cut back, more in need of relief than the top half of the income distribution of the Medicare recipients? I think the answer to that is yes.

Chairman THOMAS. Just let me say in terms of rethinking what we are doing, that in our proposal last year, we worked closely with Taft-Hartley unions who were quite concerned about people who, through contract negotiations and others, are moving into a 55-retirement period, and they have an enormous gap for 10 years, an exposure, as they are no longer under an employer benefit program. And they were very excited about our structuring and union participation retirement program that would blend in from the workplace to Medicare.

We had a couple of other initiatives, and it is interesting to me that the original argument was that we want to maintain fee-for-service because that is more like what people have in their place of employment than managed care, and that slowed down the movement toward managed care, and all of a sudden, when no one was looking, 75 percent of those people who received their health insurance from their employers are now in managed care. And if we do not create a reach-back from the workplace to the rocking chair and create a seamless blend in those kinds of programs, we are going to lose a real opportunity to be innovative.

I noticed it was not in the President's program, although he has moved toward the provider-sponsored organizations, but I think if we focus on who it is that is offering it, and for those who are willing and need a transition kind of structure, if we can work with employers through the 100-percent writeoff incentive that is in the Tax Code, we might be able to create a more receptive atmosphere for folk to build these programs that move from the workplace to retirement because when people talk about raising the retirement age—and I know Dr. Davis was concerned about that—similar to Social Security—I do not know why, mentally, we are locked into a 65 starting point for Medicare or a 67 starting point for Medicare and not looking more creatively. I am looking to you folk and your institutions for a more creative blend of moving from the workplace to the retirement program.

Are you looking at that in any way now?

Mr. REISCHAUER. I am not, but I think developments in that area would be fruitful, and of course, the way to go would be to do something similar to what Social Security has done and will do in the future, which is not to change the age at which initial eligibility occurs, but rather, reduce the benefits at each age up until the normal retirement age. An analogous approach in Medicare, if one thought it was appropriate to change the age for full benefits, would be to have the age at which you receive full benefits rise to, say, 67, but if you wanted to participate in Medicare between the ages of 65 and 67, you would be asked to pay more substantial premiums.

Chairman THOMAS. These are the kinds of discussions that I think need to take place in this Subcommittee and in Congress, and I share your concern that to the degree we take easy outs like moving money to buy time for time's sake, we are going to leave them to a commission, and in my historical analysis of the commissions, even the much praised 1983 Social Security Commission, did not do a really good job. I hope you keep the pressure on us to try to make as much policy change as we can in the short run.

The gentleman from California.

Mr. BECERRA. Thank you, Mr. Chairman.

Ms. Davis, if I could ask you to turn to chart 4, I have a question regarding the costliest decile of beneficiaries. Do you know what the characteristics of that group might be? Is it that they are the oldest and therefore the sickest, and they are needing the most intense treatment? Are they the folks who are at that last stage of life, or are they wealthy individuals who make use of services more because they are informed about their access to these things, or are

they the poorest of individuals who do not get the care until the last moment, when the illness is worst and therefore costs most? Do you have any sense of what makes up that particular grouping of individuals who are very costly?

Ms. DAVIS. Well, we need to learn more about that. I am sure it is a little bit of everything you name. The 10 percent who are the sickest account for 75 percent of Medicare outlays. It is not just care in the last months of life. About 6 percent of Medicare beneficiaries die in any given year and account for about 25 to 30 percent of Medicare outlays, so some of it is care of the dying, but that is not the bulk of it. More of it is chronically ill people, people with conditions like chronic obstructive pulmonary disease, advanced heart disease, cancer, and it just requires a lot of care for those people.

Mr. BECERRA. And I pose this question to any of the three panelists. Is there some way we can grasp or some method we can get hold of to try to reduce the costs that we see associated with the highest decile there? I know the President, for example, is proposing a lot more preventive care. He is talking about mammography services and injections and so forth, and any time you go toward preventive care, I suspect you do save quite a bit in terms of intensive care. But are there any proposals out there that you all are aware of that would help us try to reduce the costs of the costliest beneficiaries?

Ms. DAVIS. In the employer sector, the main technique is something called "high-cost case management," which is when somebody crosses a given threshold, you basically have a person whose job it is to really work with the family as they encounter different situations—maybe something is not in the benefit package, but they will cover it if it means it avoids a hospitalization or some other high cost.

But basically, I think a lot of this cost is just given, that when things go really wrong, people need a lot of care, and some of it can be helped through preventive care—if diabetes is well controlled, maybe it does not wind up in a hospitalization; certainly, a mammogram may find something at an early stage and avoid all of the care and human suffering that goes with terminal cancer. But I think some of this is inevitable. We see this even with children, where expenditures are very skewed. We have had some recent work that tried to break it down by condition, like diabetes, and pulmonary disease is very skewed within those chronic conditions, so there is just a subset of people who are just going to have enormous complications that require a lot of care.

Mr. BECERRA. Mr. Helms, do you want to respond?

Mr. HELMS. Yes. If you look at Karen's chart 4, I think it is worth remembering something about the economics of insurance. For any one individual, it is difficult to say where you are going to be in this chart next year or 10 years from now. What you are doing when you are buying insurance is asking what is the probability that you are going to be in the last 10 percent as opposed to the first 10 percent. You buy insurance to protect yourself, if you end up in the expensive category.

As Karen was saying, the private sector has shown us that there are probably lots of things that can be done to reduce costs. But,

the problem with Medicare is that it is still an open-ended system where neither providers nor consumers have very strong incentives to ask about the cost effectiveness of the care they choose. The reason why I think we should go to more market-type principles and a more competitive system is that it would put this problem into the hands of competing plans. They would have to attract people to their plans, but they would also have to control cost.

Ms. DAVIS. But I think that that is the problem with managed care. Managed care plans do not want people in that top 10 percent, and they have techniques for figuring out how to screen them out. It is illegal just to refuse to take somebody because they have a preexisting condition in a Medicare HMO, but if you have an ad in the New York Times that says come for coffee on Tuesday morning at 10 a.m. at Broadway and 42d, only those people who read the New York Times know it is Tuesday and can get there are going to be exposed to that pitch. They have techniques, whether it is the way they advertise, the kinds of specialists that are in their plans, where their facilities are located, encouraging people to disenroll. We know from the Physician Payment Review Commission that those who disenroll have 60 percent higher expenses than the average beneficiary.

They have ways of discouraging people who are very sick from enrolling. I am saying if they are ethical and want to take everybody, of course, there are HMOs out there what will not use these techniques, but others see that very strong profitability that can be made by skimming off the healthier and will respond to those incentives.

Mr. BECERRA. If I could continue, Dr. Helms, how would you try to discourage in a market-oriented system, if you have Medicare and go toward that market-oriented system, a provider seeking only those—as we see in some cases now—individuals, those beneficiaries who are healthiest to avoid—if you are going to use the market principles to try to drive your decisions, obviously, as Ms. Davis has said, you are going to avoid the folks who are the costliest, and you may, in making choices about how to reduce costs, not look so much at a preventive procedure as much as an approach to seek out only those who are healthiest.

Mr. HELMS. I am certainly not going to defend every practice of every HMO in today's market. I do think they presently have some incentives to avoid the expensive people. But we are talking about the future. If we continue to grind down on reimbursement rates, we are going to get more access problems.

It will not be easy, but I do think you can create the kind of competition where providers and health plans are going to go after the sicker population, and they are going to be encouraged to keep them. Inevitably, as people get older, they are going to have more and more problems. Health plans are going to have to convince people that they are the plans that can take care of them.

What we are really talking about is developing competition more on the basis of quality. I see quality competition happening in most other nonhealth care markets, and I think that eventually, it can happen here, too.

Mr. BECERRA. I would think that under that approach, though, if you do go toward a market-based approach, you are still going

to have to find a way to have competition almost by segment of that population of those beneficiaries, so that there is almost a competition for the healthiest, and there has to be some form of competition for those who are most ill.

Mr. HELMS. That is right, and it gets back to the question that was raised earlier about trying to have some kind of health status risk adjustment. If people have an incentive to adjust, then we will get more research on this. I think we could begin to make some progress in this area.

Chairman THOMAS. Xavier, I will tell you that it is illegal to do that. There is no question it is done subtly, and our job is to make sure we have a very strong and appropriate punishment mechanism for those who would in fact try to cherrypick or select.

One of the things we do not have, and it is very frustrating, and you will get more frustrated as we go along with this line of questioning, is that we really do not have good computer patient records. Managed care companies have as good as any, and we need to acquire them. We are paying for the collection of that, and they hang onto them, so they must have some proprietary value. We want them, because our problem is we do not have the kind of outcomes research models that we need that would lead us to guidelines for heroic intervention or others. But fundamentally, the problem is that this society refuses to have a meaningful dialog about life and living, quality of life versus quantity of life, and that there is to a degree, at this last period, a failure for the society to face quality versus quantity and offer reasonable and appropriate alternatives that are not just cost centers, but that focus on the way you deal with people on the quality side versus the quantity side. Our job is to create a structure with malpractice reform and others that the providers feel comfortable about, and we push them to engage folks in this discussion—but unless we can provide them with clear outcomes research that if you continue this, this is the outcome, it is going to be very difficult for us to begin to slow down the process of continuing to put money in these particular areas.

Mr. BECERRA. Absolutely.

Chairman THOMAS. It is very tough for decisionmakers. We are certainly not going to lead the society in determining who gets what, but the society has got to have a dialog with us. It is a very, very tough area, but we have got to engage in it, because if we do not, current medical technology will be a black hole that will consume every dollar that this society can——

Mr. BECERRA. Everything has to be on that table. Mr. Chairman, if I could ask one last question of Ms. Davis.

Chairman THOMAS. Surely.

Mr. BECERRA. You mentioned the problems we have trying to get the elderly poor to participate in the QMB and the SLMB Programs, and the panel raised the concern that perhaps the State should not be the entity that tries to promote utilization of those two programs. Do you have any other thoughts on what we should be doing to try to increase the number of elderly eligible individuals to get them to participate in those two programs to make sure they get the health care they deserve?

Ms. DAVIS. Well, there are ways of doing outreach to low-income seniors that are effective in increasing enrollment, and actually

just putting a notice in their Social Security check is not the most effective way.

We supported at the Commonwealth Fund a demonstration that was managed by the American Association of Retired Persons that had campaigns in communities, including things like putting it in their electric bill, television campaigns, and ads letting people know. But if you make a real intensive effort to tell people this benefit is available, people will sign up for it, if they hear about it. The main reason they do not join is not that they do not want it; they just do not know about it, or they do not think they are eligible.

The second point, I think, from the participation is just the low level of this. Even the SLMB only goes up to 120 percent of poverty, so you are really helping a very narrow segment, and there are many just above that who are already finding the kinds of premiums and out-of-pocket costs burdensome.

Mr. BECERRA. What about—and I asked Mr. Vladeck this—trying to ensure that anything you do to reach out to people is sensitive to the communities' profiles, so that if you are trying to reach out in parts of Los Angeles, and you provide some information that is solely in English, there is a good chance you are not going to get to a large sector of the Asian-descended or Spanish language-descended communities there, so you have to try to tailor your message a little bit to make sure you are getting to a lot of these elderly, low-income and in many cases somewhat removed communities to get them that message.

Ms. DAVIS. Yes, I think that that is right, too. Certainly, among minority communities, there are even lower rates of participation. Language can be a problem. One way you can get the people is to work with some of the providers in those communities, clinics that are located and catering specifically to both low-income nonelderly and elderly populations and try to get people signed up that way.

Mr. BECERRA. I know that in parts of Los Angeles, the Latino community, Asian community, and the Jewish community have been doing quite a bit of work to try to make sure that some of the elderly—for example, the Russian Jews who have come over recently as refugees—who are not going to have an opportunity to learn English as quickly and perhaps as proficiently as others might, still have access to the information through some of the centers that they may go to, some of the community-based organizations that provide services. A lot of folks are trying to target information to these elderly populations through some of those service providers that are already out there, providing them other services.

Ms. DAVIS. Yes.

Mr. BECERRA. Thank you.

Thank you, Mr. Chairman.

Ms. JOHNSON [presiding]. Thank you. I am going to go ahead with my turn to question in the absence of the Chairman, as he asked me to.

I would like all of you to comment on Ms. Davis' chart, which I think is sort of commonly accepted. At least you predict, Ms. Davis, that by the year 2000, 20 percent of seniors will be in managed care, 19.9. On what data do you base that, and particularly on

what year of data do you base that? And then I am interested in knowing whether the others agree with that estimate.

Ms. DAVIS. On chart 8, in terms of the Medicare projected enrollment in managed care plans and HMOs, that is from the Congressional Budget Office and their baseline update in January 1997; so just about 1 month ago.

I listened to Mr. Vladeck from the Health Care Financing Administration who had slightly different numbers. He had slightly higher numbers in 1996 of 13 percent instead of 10 percent are currently in HMOs——

Ms. JOHNSON. I think that that was because he was looking at HMOs and was also predicting inclusion of his PPOs and PSOs. That is my understanding of why his numbers were higher.

Ms. DAVIS. Well, under current law, HMOs, including point of service, can participate, and then there are some demonstrations of other models. But PPOs are not currently an eligible plan.

Ms. JOHNSON. But presumably, at least according to Mr. Vladeck's testimony, he is trying to open up the system and put more plans out there——

Ms. DAVIS. Yes, but I think he was talking about under the President's budget, he expected 22 percent of Medicare beneficiaries to be in HMOs by the year 2002. He estimated that 19 to 20 percent would be in there in current law. I think CBO by the year 2002 has 25 percent in.

Ms. JOHNSON. What I am interested in——

Ms. DAVIS. Under any of these, we are talking about a doubling.

Ms. JOHNSON. What I am interested in is, Do you have any idea what data and how recent the data is that they are basing those estimates on? That is what I am interested in.

Dr. Reischauer.

Mr. REISCHAUER. I think that what we have here is simply what the trends have been over the last couple of years. Medicare HMO enrollment grew by 36 percent in 1996. CBO has laid out growth rates of 30 percent for 1995, 25 percent for 1998, 20 percent for 1999, and so on.

Ms. JOHNSON. Why do they decline?

Mr. REISCHAUER. Now, the nature of those numbers—25, 20, and so on—should make you realize that these are rather crude approximations, and of course, much will depend on changes that are taking place in the marketplace.

This is a question of how attractive HMOs are relative to the fee-for-service world. Much will depend on how rapidly Medigap insurance premiums rise. If they rise very, very rapidly, then one would expect HMO enrollment to grow even faster.

Ms. JOHNSON. I think that that is exactly what I was trying to get at. In my State of Connecticut, where we have been slow to develop managed care products and particularly in the senior category, the number of HMO risk plans has just exploded, and the number of options seniors now have and the aggressiveness of the marketing has totally changed the environment. And this is at a time when Medigap premiums are now beginning to go up. And there is just absolutely no way, in my mind, that we are not going to be way ahead of 20 percent.

I think those kinds of figures underestimate our experience in managed care where market maturity now takes place far more rapidly than it did 5 years ago, 4 years ago, 3 years ago. In other words, where these plans get in and get marketing, the pace of enrollment goes much more rapidly. We saw this in the private sector, and one section of Connecticut went from zero managed care participation to a very high level in 6 months. The maturation of that market now that we know more about it and the plans are more sophisticated takes place much more rapidly than it did in the early years of managed care or even the midyears.

My guess is that these figures are way low. We are not going to solve that here, but I want it clearly in the record that, really, the data they are using and the interaction of the facts make these estimates very, very unreliable.

Mr. REISCHAUER. I think you are right, they are very uncertain. There are factors moving in the other direction. We know that HMOs are more attractive to relatively healthy younger groups of retirees. As those retirees age, the question is will they find fee-for-service relatively more attractive and higher fractions of them disenroll. Right now, disenrollment is very, very low. A lot of the proclivity to disenroll will be affected by what happens to Medigap premiums for those who disenroll. Right now, they effectively could lock one into the HMO because they would be risk based. But if you changed the policy as the President has proposed, you might see more of this churning. So, I think——

Ms. JOHNSON. But as one who has actually introduced the first bill to assure portability so that seniors can come back, I think that is important, and I think we will do it. But it is also very interesting to watch what is happening on the other side. One of the disadvantages of HMOs was that you were sort of locked into their doctors. Now, all of a sudden, at least in Connecticut, HMOs are saying you can go to any doctor you want—not all of them, but some of them. They are now in the competitive market beginning to break down the very barriers that in a sense help them control costs or gave them an advantage, but also gave the consumer disadvantage.

For instance, in my area of Connecticut, there are a couple of very big physician groups; they are now in every plan. Your access to, in a sense, the largest number of specialists in every area is the same no matter what you are in.

I think we are underestimating the power of the fact that—and this goes right to the heart of this business of protecting low-income seniors—I see seniors much more interested in this because Medigap covers some costs but they cannot afford the premium. And I do not see a single new managed care risk program on the market that does not cover Medicare copayments and deductibles and that does not provide some prescription coverage, that does not actually improve the benefit package quite significantly and reduce out-of-pocket costs quite significantly.

If the managed care sector keeps this up, not only will it grow more rapidly than anyone is projecting, but people with high medical costs will stay if all their doctors are part of the plan, as is evolving now, at least certainly in my small part of the country.

I want to contrast that to—and I am curious, Ms. Davis, that you really prefer the old model of concentrating on expanding benefits and expanding protection and regulating rates, because I have here a page from the administration's worksheets, and this only has to do with overhead costs. But one possible proposal—and nothing has been settled on—but one possible proposal would cut reimbursement rates for cardiac surgery and cardiology, two of the big use areas for seniors, anywhere from 32 to 44 percent.

Now, this is going to reduce access. If we keep regulating rates this way—internal medicine, they allow a 1-percent increase, and 1 percent to 4 percent are the options there. Truly, we are squeezing down, and we saw this in Medicaid. In Medicaid, we reduced access for poor people dramatically. In my hometown, they went from having a full range of access to all obstetricians down to just the one public clinic. Now that we are into Medicaid managed care plans, they are back up to all the physicians who participate in those plans.

We are really at a point now where we have to keep two systems running, but we also have to look at how rate reimbursements are going to reduce fee-for-service access versus how managed care plans may have the opportunity to not only increase access to benefits through managing care, but provide rates that are comparable to private sector rates, because the HMOs are going to be covering not just seniors but everybody else eventually.

I do not know why you would want to keep going down this path of micromanaging rates when we have the opportunity now to begin moving gradually down the path of a uniform set of rates covering all of society, with government assuring, through appeal procedures and oversight, access to specialty care and those kinds things that we know need to be watched in integrated care systems, and focusing on prevention, which has never been part of the fee-for-service system in history.

Ms. DAVIS. Well, first of all, I do not favor fee-for-service over managed care. What I think is healthy is a healthy competition between both, where you have quality in both a fee-for-service option and a managed care option.

What I say in my testimony is I think what we all know—fee-for-service does have an incentive for too many services at too high a cost. Managed care has an incentive for too few services at too low quality. And you do not want to have seniors forced into managed care and not have a viable fee-for-service alternative. You do not want to undermine the quality of fee-for-service by setting prices so low that no doctor wants to practice under those circumstances.

I think the point you make, that you do not want to drive fees in the fee-for-service level too far below the private sector, currently—and I am sure you will get the latest update from the Physician Payment Review Commission, but their reports show that Medicare pays 70 percent of what private insurers pay physicians. You cannot keep squeezing that and driving it down to Medicaid levels of 30 or 40 percent and not affect the willingness of physicians to take Medicare over the long term.

Ms. JOHNSON. Absolutely.

Ms. DAVIS. I noticed in the CBO baseline estimates out to 2002 that even under current law, the typical physician fee will basically be the same 6 years from now as it is today. I am concerned about squeezing too much, and that is why I think the President's proposals are adequate savings, and I would not try to do more than what he is proposing in the way of payment squeezing under this.

Ms. JOHNSON. But you think he is not proposing too much?

Ms. DAVIS. Excuse me?

Ms. JOHNSON. You think some of his proposals are adequate?

Ms. DAVIS. I am saying that if you tried to, say, double the provider payment savings he is proposing, you will really have to worry that Medicare is getting too far out of line with what physicians and other providers are paid in the private sector, and it would reduce willingness to participate.

Right now, physicians in fee-for-service are perfectly willing to take Medicare patients. There is a point of squeezing provider payment that you do not get provider participation.

The point you made about managed care aggressively marketing to Medicare patients, they are giving extra benefits, prescription drugs out of pocket, I think it should also raise a question in your mind as to whether we are overpaying HMOs, and that is one of the reasons why they want this Medicare market. I think you have to look at both. You have to both worry about paying physicians too little on the fee-for-service side, and you have to worry about overpaying HMOs and not being able to keep them from cream-skimming this healthier population.

Ms. JOHNSON. My point is, Ms. Davis, that if you are trying to control future cost, which is primarily our goal, and do it in a way that improves the benefit package and improves protection for poor people, we are better off with keeping the premium payment for the managed care plans high enough so they can improve the benefit package and give our low-income seniors the option of just the Medicare premium, not additional Medigap premium, getting a much better, lower out-of-pocket cost plan.

I do not want to ratchet that down because that achieves both of your goals of better benefits and better protection for low-income folks, and I think that that is what we ought to be focusing on because we can do a better job there than we can micromanaging all of these rates. It is simply appalling—dermatology goes up, the general internist, the family practitioner. This has created endless problems in the last 20 years, and they get worse every single year.

I think from the point of view of consideration of the poor and consideration of a modernization of the benefit package, it looks to me like we are having far greater and more success in that with overseeing managed care plan development than we are with micromanaging reimbursements. I guess that is really my point.

And my time has certainly expired; I guess they forgot to turn the light on. Let me yield to Mr. McCrery.

Mr. MCCRERY. Thank you.

Dr. Reischauer, why do you say it is more important to do structural reforms now, or start some structural reforms now, than it is to worry about the number of $50 billion or $100 billion or $150 billion in savings?

Dr. REISCHAUER. Because the real problems Medicare faces are not the problems that will exist over the next 5 or 7 years; they are the problems that will begin to mount after about 2010. And I do not think we can wait until 2005 or 2008 to begin to address those problems because by that time, it will be too late to, in a deliberative way, start changing the structure of the program.

Mr. MCCRERY. The cumulative effect is what is needed over the years of those structural reforms.

Dr. REISCHAUER. Well, structural reform is not an easy thing to bring about. It requires building an institutional infrastructure. That takes time, and it is best to build that infrastructure at a time when you do not have inordinate pressures put on the infrastructure, either the pressures of an expanding number of recipients, or the pressures of having to say to this new infant structure, "You are going to have to save a lot of money as well as sort of transform incentives."

I think it would be wise to start the process now and get plans, participants, providers used to this new structure over a period of a decade before you had to really put heavy weight on that structure. But we are going to have to put heavy weight on that structure within 15 years.

Mr. MCCRERY. At the same time, though, you recognize our immediate problem with the trust fund balance in the HI Trust Fund, and we have got to address that one way or the other. Our preference is to create savings and see that the trust fund does not go bankrupt.

Mr. REISCHAUER. As Administrator Vladeck pointed out earlier, if all you consider are the President's actual savings in part A, you have really extended the life of the trust fund 1 year or maybe 2 years. The way that they are getting breathing room or salvation is really a bookkeeping device. You could do the bookkeeping at any point. That is not a complicated issue. You could even look back and credit the Part A Trust Fund for moneys that were spent before. Anything in a sense can be changed by a law.

Mr. MCCRERY. Except that if you want to include those costs in the calculation of the part B premiums, you have to do it prospectively; you cannot do it retroactively.

Mr. REISCHAUER. No, you could not do that, no.

Mr. MCCRERY. That would create an additional problem that you do not want to deal with.

When we have more time, I would like you to expound on what structural reforms you would recommend, but I do not want to get into all that right now. I have some idea from your testimony and from your verbal remarks.

I think the point you made, though, about shifting more of Medicare expenses into the general fund is an excellent one and one that I have tried to make in the past. The example that I give is like the Pac-Man machine. Do you remember the Pac-man game, where the Pac-man would go across and eat all the other Pac-men? If we shift Medicare into the general fund, Medicare and Medicaid will to a much greater extent than they are doing now, act like Pac-Men and eat up the rest of the budget. And you are right, the political pressure is much greater to maintain these benefits than

any array of other benefits you can think of, and I do not think that that is a very good way for policymakers to do business.

I appreciate your making that point, probably better than I have with my Pac-man example, but for some of our constituents, the Pac-man example is better.

Dr. Helms, you said your preference for a structural reform I guess is the ultimate structural reform, and that is to go to a defined contribution plan. I assume that you have given this a good deal of thought. How would you arrive at the defined contribution, and do you see problems when you go to a defined contribution plan in creating a two-tier health care system, one for the poor and one for the wealthy, or one for those who can get extra health care? Have you thought about that, and I would appreciate your remarks on that.

Mr. HELMS. Yes, I have thought about it. A basic criticism of Medicare is that it is an open-ended entitlement where everybody has an incentive to keep spending more money.

One of the objectives, quite frankly, of going to a defined contribution is to put the issue back onto the Congress. The Congress should decide, in the context of making other decisions about discretionary funding, how much you really want to pay for Medicare. And in the process, I think that would make people be more realistic and focus on the issues that Karen is raising about helping the poor.

In other words, we now have a system where the net subsidies from the tax policy and from Medicare go to higher income people. A defined contribution would force Congress to consider who we really want to subsidize. Do we want to continue an open-ended subsidy for higher income people, or do we want to take care of poor people? It is a complicated matter, but it is not any more complicated than some of the things we are trying to do in the President's budget proposal.

Ms. DAVIS. I think the point you raise about defined contribution leading to a two-tier system is my number one concern with the defined contribution approach to Medicare. Medicare, historically, was to guarantee beneficiaries, regardless of income, access to a defined set of benefits, and I think that once you go to a defined contribution, you are going to have the lower income beneficiary forced into lower quality plans, managed care plans, they will have difficulty getting appointments—they are not going to have their diabetes, their hypertension, and their heart disease managed appropriately. They are going to be discharged from the hospital before they can really take care of themselves. I think we are really getting into different medicine for different populations.

Mr. HELMS. I do not think you have to end up with a two-tiered system. As a matter of fact, I think you will get those results if you continue on this course of more and more controls.

Mr. MCCRERY. Dr. Reischauer.

Mr. REISCHAUER. Henry Aaron and I wrote a piece in "Health Affairs" in the summer of 1995 which suggested an approach that I do not think creates the problems that Karen has alluded to. The approach would have a defined benefit, a package of required benefits. Within each market area, plans would make bids for covering Medicare beneficiaries with that defined package. The contribution

the Federal Government made toward this package could be set at the 50th percentile bid or the 70th percentile bid or some bid other than the lowest bid, which would then give the low-income participants a choice of plans just like everyone else's. I think some of the problems would be mitigated by such an approach.

But it is a fact that right now, Medicare is a classless system. A provider really does not care what side of the tracks you come from because he or she receives the same payment. And any movement to plans, even an HMO type of arrangement that we have now, could, over time, break down that classless nature of the system.

Ms. DAVIS. And I think that that is a hypothetical that Congress would set the voucher at the 50 percent or the best plan level, but I think there is always a temptation in a budgetary environment to set it at the minimum level, and that is all, then, that the low income could afford, and higher income would add to that. I think you do inevitably introduce, in anything that just guarantees the elderly a fixed amount of money to buy health care as opposed to buying health care, this kind of introduction of income differentials in the care available to seniors.

Mr. MCCRERY. Let me tell you my concern, Ms. Davis, if we do not go to some different system than the one we have now—radically different. My concern is that ultimately, we will reach the point where everybody will get lower quality health care in this country, because I just do not see how we can afford as a society to give everything the health care system has to offer to everybody on the same basis. If you do that, you are going to reach the lowest common denominator for everybody, and that means that health care quality is going to go down for everybody in our society, and that is not a desirable goal to me as a policymaker. Now, somebody in the old Soviet Union may like that idea; I do not think it worked too well there.

I am trying to figure out a way we can avoid that result and yet not create a system in which we have a great many people in our society not getting an adequate level of health care, and I am hopeful that smart folks like you will help us figure out a way to reach that middle ground.

Ms. DAVIS. Well, I think we all share the same goal of wanting quality care for all of our seniors, and I do not think anybody defends the current system. I just think we need to move slowly on managed care, and we need to adopt the prospective payment approaches Medicare has used successfully with hospital and physician services to the other services, which is really where the Medicare costs are going up quickly—home health, hospital outpatient department, and other services.

Mr. MCCRERY. Yes. I want quality health care, too, but I do not necessarily want the same level of health care for everybody, and I think that that is a key question that we have got to broach and discuss as policymakers and as a society.

Ms. JOHNSON. I share a lot of Mr. McCrery's concerns, and I am not sure you are as realistic as perhaps you need to be about what is happening in the system out there now. There are, for example, five reimbursement rates for office visits, and what I have seen happen, year after year, as we get closer to the end of the budget

year, is that HCFA simply just pays the lowest rate for office visit, which is something like $32 in my part of the country, and it does not matter whether you have a complete physical, it does not matter whether you can document a higher rate. The provider is caught between do I write five letters now to document rate 3 or rate 4 which I should have had, because HCFA keeps coming back to me with, We are going to give you $25 or $32 or whatever the lowest rate is?

That is what is happening out there. Recently, HCFA announced to physicians in my area that they are no longer covering certain preventive things that they used to cover routinely, and now they are saying, Oh, they are preventive, and we do not cover preventive.

There is a lot of cost cutting going on behind the scenes that is denying seniors the care they used to just take for granted, and it is beginning to affect access particularly in internal medicine.

I think this issue of moving forward into plans that serve people of all ages with the same premium for seniors as younger people is absolutely a healthier answer, but I want to ask you one thing, because this is the heart of and a very big part of the administration's proposal. What is your opinion—and you may not know much more than I know, so it is hard to make judgments—but if in 1 year, you remove GME, IME, DSH from the AAPCC, you will have a very dramatic effect on the reimbursement rates of certain hospitals. Now, I do not know much about how they feed some of this back in—maybe you know more about that than I do—but basically, IME and DSH are there because we do not really know how to compensate the system well enough for uncompensated care, and to just suddenly drop these out of the AAPCC and believe that you are going to have a system providing the same level of care seems to me very unwise and not in harmony with our discussions about those factors in the payment system in the past. If you have any comment on that, I would be interested to hear it.

Ms. DAVIS. Well, I do think we have to be concerned about how these changes affect teaching hospitals and those that serve low-income communities. As I understand the proposal, those savings will be put into a special fund and then go directly to the teaching hospitals to cover the indirect and direct graduate medical education costs. As I understood it, they were not being used for general budget savings but were being put into an earmarked fund that would go directly to those institutions.

Ms. JOHNSON. But, as you well know, you are into a new distribution system and the administrative cost of that and the inaccuracy and accuracy of that.

Mr. REISCHAUER. What we are talking about here is taking money out of the capitated payments going to HMOs and distributing that money directly to the provider hospital. It is likely now that some of that money never reached the teaching hospital because the HMO was not using the teaching hospital, in which case if the distribution mechanism is appropriate—and I do not think it is very complicated to get one that is appropriate—teaching hospitals should be better off than they were.

Now, the HMOs, of course, will have to tighten their belts a little because they will have a little less in the way of a capitated pay-

ment which they can use to provide services or increase their profits, but I do not think there is anything in the administration's proposal which should cause great concern for the teaching hospitals or DSH hospitals, as well, if this money is simply recycled.

If anything, those institutions should be better off under the administration's plan rather than worse off.

Ms. JOHNSON. Well, I can certainly see that in regard to the IME and DME. I really worry about the DSH payment as well, because there are hospitals with a lot of DSH money that do not have a lot of DME money; in other words, the line is not clear.

Mr.REISCHAUER. But I think there would be a separate mechanism for distributing the DSH money. This once again is payment taken out of the capitated amount given to HMOs, and the question is, "Were the HMOs using facilities that were DSH facilities?" The answer is probably, "Not very much." They were in a sense pocketing this money.

Ms. JOHNSON. Yes, and philosophically, the larger issue of DSH money is for people who cannot afford very good care. Don't you want some of that to go to the premium that you offer HMOs so they will provide broader protection which lower income people need? I need for them to be able to provide a package to all those seniors who are eligible for Medicaid coverage that will take care of their copayments because they cannot afford their copayments and will offer them some prescription coverage.

When we worked on this for a couple of years recently, we just took the money out of the general fund, saying education is something not just seniors should be concerned about, but medical education is everybody's business, and that is a legitimate taxpayer fund. And I think that philosophically, it is important at this time that we try to make those distinctions between what serves us all, and therefore, is general revenue as opposed to general revenue now picking up home health care for seniors. I think we need to keep the cost of home health care for seniors in Medicare so that we are clear what it is costing us to deliver care to seniors, and also encouraging HMOs to better integrate hospital and home care and all those kinds of things, and then separate out the teaching costs and bear some of those costs across the general taxpayer. To me, that is philosophically cleaner, and I think that eventually, it could be system cleaner.

Mr. REISCHAUER. I think you are right on about that. I agree with you 100 percent, and I think the Balanced Budget Act measures to do that were in fact quite sensible. I also agree with your feeling that it is good to have HMOs providing a comprehensive benefit package, more than Medicare requires, with low cost sharing by participants. But we have got to remember that that is in conflict with the desire to save money. HMOs are able to do this because we are overpaying them relative to what these individuals would have cost in the fee-for-service sector where these ancillary services and the low cost sharing would not be available or would be available only if the individual purchased a Medigap policy or had an employer wraparound retiree policy.

There is this tension between what is good and the desire to get Medicare spending under some kind of control.

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Ms. JOHNSON. Yes, but your issue of overpaying depends on whether or not the HMO is able to deliver more benefits because they are more efficient and they do a better job—and some of that is certainly true. It is also true that managed care is our only hope of delivering better preventive care because the fee-for-service system does not look at a patient holistically; it looks at it physician by physician, incident by incident. So that if prevention is every going to mean anything—and of course, you see this in Medicaid managed care, where for the first time, we really are looking at prenatal care and able to demand and deliver prenatal care that reduces the number of low-birth-weight babies, and you get extraordinary savings—so a more holistic approach to medicine is one of the opportunities we have in managed care, and rather than talking about we are going to overreimburse, let us talk about what we need to get, because our real challenge is to slow the rate of growth at the same time we improve the quality of the package and turn to prevention.

And if you look at that chart about their high costs, maybe the one thing we ought to be looking at it is, How does government take care of the outlier. One of the things that concerns me in the President's package is that they are going to eliminate any reimbursement for outliers, which I think is a problem for very small hospitals.

I think maybe we have got to keep pushing ourselves to broaden our thinking so that we get the low-income concern, and we get the better benefit package, and we in the future gradually control costs.

Incidentally, would you all agree as economists with Mr. Vladeck's statement—which was new to me, and I do not know a lot—that if you put the savings in place now, it is not surprising to get one-third of your savings in the last year—because one of the things that does concern me about this budget is that $34 billion of the $100 billion is all in the last year. Does that mean there is a precipitous cut, or is that the cumulative impact?

Mr. REISCHAUER. No. It is true that savings compound over time, so well over half of the savings that result in sort of equal percentage reduction in spending occur in the last 2 years of a 5-year package, so that is not——

Ms. JOHNSON. Fifty percent in the last 2 years——

Mr. REISCHAUER. Well, not—actually, I am not talking about Medicare now. I am talking about if you wanted to balance the budget solely by reducing the growth of spending, and you reduced the growth of spending by an equal percentage in each of the 5 years, 62 percent of the total saving would occur in 2001 and 2002.

Ms. JOHNSON. Thank you. That is very helpful.

Mr. REISCHAUER. That is just arithmetic.

Ms. JOHNSON. Thank you.

Mr. Helms.

Mr. HELMS. Yes, my testimony refers to this as the "wedge effect." If you have 2 trendlines going off at different rates, as they diverge, you are going to have bigger effects in the outyears. But that is different from the criticism of this budget of its backloading policies, that is, putting in policies which only kick in the last year or two after President's Clinton's term is over.

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Ms. JOHNSON. Those are two different things. I am pleased to have confirmation. I have been aware of the compounding, but I did not quite realize that, generically and generally indicated, it was that high. Thank you very much.

Thank you for your thoughtful testimony this morning. We look forward to your input as we work through this challenge. As I said earlier, I know I feel, and I know that particularly Jim and some others feel, very strongly that this year, we absolutely have got to try to do this job right because of the compounding effect of problems created or not addressed. We thank you for your input.

The Subcommittee is adjourned.

[Whereupon, at 12:37 p.m., the hearing was adjourned.]

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